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*Patient-Physiotherapist Relationships in South Indian Outpatient Settings: An  
Ethnographic Discourse Study*

CHETTYAR, Soumya Shanmughan

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# **Patient-Physiotherapist Relationships in South Indian Outpatient Settings: An Ethnographic Discourse Study**

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Philosophy

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## **Abstract**

Therapeutic relationship traditionally has been considered as one of the non-medical factors that influence on patient's treatment outcome. Previous literature explored the different dimensions of the relationship between patients and various health professionals in healthcare settings. However, in the field of physiotherapy, only very limited number of studies explored the social dimension of the therapeutic relationship. So, the purpose of the study is to identify how the interactional features, contextual factors and the underlying power mechanism influence the formation of the therapeutic relationship in the outpatient physiotherapy settings in South India. Critical realist ethnography is adopted as a method of this study (Hammersely & Atkinson, 2007, Sinead, 2017). Data were collected from outpatient physiotherapy departments in Kerala. Total 21 physiotherapists and 36 patients have participated in this study. Participant observation and semi-structured interviews were used to collect the data. The data collected in the local Malayalam language were translated to English and analysed using the elements from Fairclough's critical discourse analysis and pragmatics (Fairclough, 2001; Alba-Juez & Mackenzie, 2016).

Patient compliance to the treatment, solidarity forming conversations and issues associated with expectation are identified as the main elements that influence in creating the better therapeutic relationship. Based on these findings, three therapeutic relationship models were identified include mutual, consumerist and paternalistic therapeutic relationship model. This study discussed the possibilities of how the different elements associated with these models influence the formation therapeutic relationship. The findings of this study enable the Indian physiotherapist to identify the underlying social phenomena and provide an opportunity to determine how to create the better therapeutic relationship based on that. Also, this study acknowledges and provides an insight to the global physiotherapist to think further about the important role of the power discourse and the social exchange happening between the therapist and patient in different aspects of the therapeutic process.

## **Acknowledgement**

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## **Candidate's Statement**

I declare that the work in this thesis was carried out in accordance with the regulations of Sheffield Hallam University and is original except where indicated by specific reference in the text. No part of this thesis has been submitted as part of any other academic award. The thesis has not been presented to any other educational institution in the UK or overseas. Any views expressed in the thesis are those of the author and in no way represent those of the university.

## **Conference Papers**

Shanmughan Chettyar, S and Grafton, K. (2017). 'Socio-cultural factors affecting patient adherence in physiotherapy settings in India'. 18<sup>th</sup> World Confederation of Physical Therapy Congress, Cape Town

Shanmughan Chettyar, S and Grainger, K. (2017) 'Patient compliance and the therapeutic relationship in Indian physiotherapy: an ethnographic discourse analyses. British Association of Applied Linguist (BAAL) Health and wellbeing SIG workshop November 2017, Lancaster University.

# Chapter 1: Introduction

Much of the previous literature from different disciplines identified that not only the medical intervention, but also the non-medical factors possessed an essential role in determining the treatment outcome in health care settings (Figure1.1). The therapeutic relationship traditionally has been considered as a significant non-medical factor to influence treatment outcome (Hush, 2011; Benedetti, 2013). Different disciplines include psychology, sociology, philosophy, neurosciences and health policy have approached the therapeutic relationship, from different perspectives. However, in the field of rehabilitation, the concept of the therapeutic relationship has not been widely explored yet, especially about the underlying social phenomena. A limited number of studies analysed the social process involved in the therapeutic relationship, but were in the context of developed countries. So, this study explores the social phenomena of the therapeutic relationship in the out-patient physiotherapy settings in south India by using an ethnographic discourse approach. This study's original contribution to knowledge is to analyse the interactional features, contextual factors and the underlying power mechanism influence the formation of the therapeutic relationship in a single study by using discourse analysis. Thereby, it enables the physiotherapist to identify the underlying social phenomena and provide an opportunity to determine how to create the better therapeutic relationship based on that.

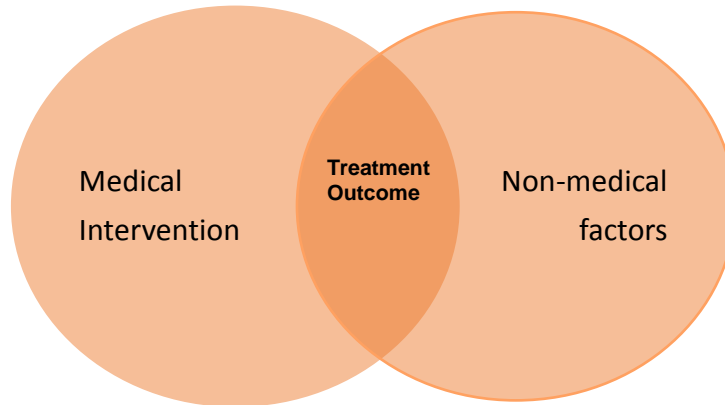


Figure: 1:1 Importance of the non-medical factor and medical factors in determining treatment outcome.

The therapeutic relationship has also been labelled as patient-provider interaction or therapist-patient encounter or therapeutic alliance. According to Leach (2005), the therapeutic relationship is a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy, mutual understanding and respect. The concept of the therapeutic relationship originated in early psychoanalytic practice, which was developed by Freud in the early 20<sup>th</sup> century (Martin, Garske & Davis, 2000). Initially, Freud considered the relationship between therapist and patient as purely negative by referring the theorisation of transference (when patients project repressed wishes from the past onto the therapist) and recommended to the therapist to stay rational and "maintain a professional distance at all times" (O'Brien, 2001). However, in his later works, Freud himself criticised this stance and identified the possibilities of the beneficial attachment between therapist and

patient (O'Brien, 2001). However, until, Rogers suggested the person-centred therapy the scope of the therapeutic relationship to produce beneficial results in health care had not been explored widely (O'Brien, 2001). Nowadays, many health care systems in almost all developed countries have adopted the principles of therapeutic relationship and patient centred care to improve the health care outcome (Martin, Garske & Davis, 2000). However, some of the literature critic the concept of patient-centredness and suggested a patient- perspective care (Pluut, 2016; Timothy, 2016). This literature also emphasised the importance of therapeutic relationship.

The number of research conducted in developed countries is high to identify the different dimensions of the therapeutic relationship. In developing countries, the existing knowledge and the research regarding the therapeutic relationship is limited. The rapid urbanisation, globalisation, rapid advances in technology, and communication has brought social changes in the societies of developing countries that include the nature and shift in family systems, newer patterns of relationships, migration and social mobility. These in turn bring changes in people's values, beliefs, and attitudes (Altamimi, 2015), which are highly likely to influence the different dimensions of patient and therapist relationship in health care. So, it is relevant to conduct research about the therapeutic relationship in the context of developing countries like India.

The therapeutic relationship has different dimensions. This research explores the contextual, power and interactional aspect of the therapeutic relationship in South Indian outpatient physiotherapy settings. The following section will discuss the relevance of the contextual, power and interactional aspect while considering the therapeutic relationship as a topic of research.

## **1.1 The relevance of context, interactional features and power to knowing the social phenomena of the therapeutic relationship.**

Socio-cultural factors and the clinical context possess an important role in the patient-therapist interaction as this does not occur in a vacuum (Von Raffler-Engel, 1989). Physically and psychologically, the patient-therapist interaction takes place in a particular socio-culture context. Fairclough (2001) stated the principle that, texts can never be understood or analysed in isolation, they can only be understood in relation to the discourse practice and in relation to the wider socio-cultural context. Here, the text means the communication between patient and therapist and is an example of institutional talk. Institutional talk is closely connected with 'institutions' and the settings in which it occurs. These institutions, and organizations, such as school, court or clinical setting determine Fairclough's discourse practice. The socio-cultural context of the interacting members (here, the patient and therapist) influence their communication. Both members of that interaction bring their understanding about the culture and the contextual knowledge to that situation. Especially, their knowledge about the culture-specific regulations and organisational rules that direct their interactions or influence their interactions in that specific event (Burke & Elizebath, 2013). So, it is essential to know about the wider socio-cultural as well as the clinical context to understand the social phenomena of the therapeutic relationship.

Individuals possess power (Danermark, Ekstrom & Jakobsen, 2005); so, if they interact, the power also interacts. Therefore, power is present in all relationships, or it can be said that power exists in all forms of formal as well as



informal relationship, which includes the therapeutic relationship. This power is dynamic and it varies according to the context. Usually, the power in the relationship cannot be observed easily, which is frequently hidden. According to Fairclough (2003), the patient and therapist interacting in a clinical setting possess power, which is ascribed by the societal structure and institutional settings. For example, the therapist possesses the power of medical knowledge and skill; this provides them with the role of an expert in the clinical setting while they are interacting with their patients. Societal structures, such as class, gender, or race have causal powers over the therapist and patient. Fairclough (2001) argued that there are power relations in the surrounding society, which have an impact on the interaction that people are not always even aware of, and these hierarchies and relations have an effect on the institutional power relations. So, it can be argued that each of the subjects interacting in an institutional setting possessed a combination of institutional power and causal power that ascribed by the societal structure (causal power of age, class and gender). All these possessed powers have an effect on interaction while the subjects interact with each other in an institutional setting.

The nature and balance of power vary within relationships (Goodyear & Buetow, 2001). It was argued that power imbalance is inherent in patient and health professional relationship. Patients approach health professionals to seek help, thereby the patients themselves place the health professionals in a position of power (Buchanan, 1995). The power is expected to be used in a positive way to help the patient.

In certain situations, the societal power enacted with the professional power and it could be negatively influenced the therapeutic relationship. For instance, if the health professional possessed a dominant societal power, there might be

occurred a tendency to devalued the patient's values and perceptions by the health professional (Hall, 2003). In such kind of situation, this power imbalance becomes exploitative, and it could be negatively influenced the therapeutic relationship and treatment outcome. Gender has been identified as an important factor that influences power disparities in physician and patient interactions (Hall, 2003). An Indian study about physician-patient power imbalance illustrated that gender was a factor behind the power disparities (Fochsen, Deshpande & Thorson, 2006). The study identified male patients were sometimes perceived as less cooperative, than female patients, as they challenged the doctors' dominance by being more demanding, switching doctors more frequently, and questioning doctors' knowledge and skills. Literature from Europe and the United States about physician-patient relationships have shown that female doctors tend to engage in longer consultation and more rapport-building than their male colleagues (Roter, Hall & Aoki, 2002; Van den Brink et al., 2003).

Various factors influence the nature and balance of power relationship in health care, in which context is one of the important factors. For instance, in a private clinical context, the patients are likely to be the group with the greatest potential for adopting a consumerist relationship with the therapist and this offer more power to the patient than the health professional. A consumerist relationship is explored both in its negative as well as the positive way in literature (Lloyd, Lupton and Donaldson, 1991). Consumerism enables the individual choice within a health care marketplace characterised by the exchange of money for health care goods or services (Madison, 2010). In making these choices, medical consumers, like other kinds of consumers, rely on information gleaned from multiple sources in determining which purchases will best satisfy their needs and desires (Madison, 2010). However, in consumerism clients have become better

educated about health care options and their rights (Marincowitz, 2004). Consumerism encouraged people to make demands but, failed to emphasise reciprocal responsibilities (Marincowitz, 2004). In consumerism, provider serves as a hired consultant. So an imbalance of power is apparent in the consumerist relationship.

The greater the imbalance of power, particularly when some minimum threshold of power has not been achieved by either party, the greater the capacity for its misuse in every relationship. So it could influence the relationship in a negative manner. Much of the previous literature identified that balance of power tends to favour health professional and patient relationship (Parsons, 1951; Henson, 1997; Charles, Gafni & Whelan, 1997; Gwyn & Elwyn, 1999). The balance of power or mutuality was the core concept of many recommended models of the therapeutic relationship between the different group of health care professionals and patients described by previous literature in various clinical context. So, it is essential to acknowledge how power shapes, informs and presents itself in the therapeutic relationship in the context of Indian outpatient physiotherapy settings.

Power can be defined as 'the ability to do or act' (Goodyear & Buetow, 2001). However, the enactment of power is not simply a form of action, but a form of social interaction (Van Dijk, 1989). This form of social interaction can facilitate healing through creating a positive therapeutic relationship between patient and therapist. In a certain situation, the therapist cannot cure the patient's condition, but can ameliorate the patient's condition using the concepts of power (Goodyear & Buetow, 2001). For instance, ameliorate the patient's condition by sharing similar life stories or suffering that they had experienced in their lifetime (Goodyear & Buetow, 2001). By sharing this kind of experience the therapist is

openly expressing their powerlessness and vulnerability to make a positive change in the patient (ameliorate patient's condition) (Goodyear & Buetow, 2001). This kind of acknowledgement of powerlessness and humility may be one of the most powerful things that the therapist can use to facilitate healing in patients. Here, the therapist could share the weakness to illustrate solidarity with the patient. So, it could be considered as an interactional strategy used by the therapist to express the power or powerlessness to improve patient healing. This way of approach, in turn, enhance the therapeutic relationship. It can also be viewed as the therapist's awareness about the shared weakness can be used as a strategy to illustrate solidarity to enhance the therapeutic relationship and facilitate healing. So, power can be used either in a positive way to facilitate the therapeutic relationship or in a negative way to restrict or control the relationship (Goodyear & Buetow, 2001).

According to the above example power is put into action through "strategies" (Foucault, 1982). These strategies are observable in the way that the participants express themselves through language (Bourdieu, 1991). So, the language or the interactional strategies possess an important role in therapeutic relationship to know how the therapist and the patient strategically handle their power while they are interacting each other in that particular clinical and cultural context. For instance, previous literature showed solidarity or illustrating negotiation are the interactional strategies that enable the therapist to share power and enhance the therapeutic relationship (Thomson, 2008; Defibaugh, 2014).

The resistance or controlling interactional strategies possibly leads to misuse of power and could affect the therapeutic relationship in a negative manner (Thomson, 2008). For instance, one of the main philosophical underpinning of physiotherapy is to encourage the patient to take an active role in their

rehabilitation. However, not all the patients like to take an active role in their rehabilitation and such patients believe that others are responsible for their condition. So, the active treatments could be affected the beliefs of the patients. In this kind of situation, the therapist failure to provide the passive treatment strategy to the patient possibly lead to patient reistance and a clash in between their possessed power. This, in turn, influences the therapeutic relationship.

From the above descriptions, it is clear that the social context, power relationship and interactional strategies are the significant elements to focus on while exploring the underlying social phenomena of the therapeutic relationship. Therefore, the objectives of the study include:

- To identify the involvement of power in patient-therapist relationships in an Indian outpatient physiotherapy setting.
- To understand the patient-therapist interactional strategies and how it influence in creating therapeutic relationship in an Indian outpatient physiotherapy settings.
- To identify the institutional and societal contextual elements that are associated with the therapeutic-relationship in an Indian outpatient physiotherapy setting.

## **1.2 The researcher context**

The researcher was born and brought up in a middle class family in a village in South India; belongs to the Vaishya caste (Caste system in India describes in chapter 2). After the completion of higher secondary school due to an interest in medical-related subjects the researcher was searching for different courses and got admission to a physiotherapy course. Until joining the course physiotherapy was an unfamiliar profession for the researcher. This was due to the lack of

awareness about physiotherapy in Indian society at the time. After graduation in physiotherapy the researcher migrated to the UK in 2011 for further studies. Higher education in the UK provided the opportunity to the researcher to explore physiotherapy in different cultures. While studying in the UK realised the wider scope of research in the field of Indian physiotherapy. According to the researcher perspective, there is a little knowledge among Indian physiotherapy professionals about the importance of non- medical factors and how it influences the different aspect of therapeutic outcome. Lack of literature emphasising the non-biomedical factors in Indian physiotherapy field is an example of this. So, this could be one of the reasons that inspired the researcher to think about the therapeutic relationship as a research topic for this thesis.

### **1.3 Summary of the chapters**

#### **Chapter 2: The Literature Review**

This chapter discusses the role of therapeutic relationship in the field of physiotherapy, and is comprised of three main sections. The first section reviews previous literature related to therapeutic interaction. Secondly, chapter two describes the health care systems, history and development of the physiotherapy profession in India and the current issues related to physiotherapy profession in the context of India. Discussion of these subjects not only provides information about the background of Indian physiotherapy profession but also helps to recognise the status of power that the physiotherapist possessed currently in the society of India. Also, this section explores certain socio-cultural aspect including the social hierarchy that exists in Indian society. Finally, this chapter includes the reasons for choosing the therapeutic relationship in the context of Indian outpatient physiotherapy as a topic for this thesis and objectives of this study.

### **Chapter 3: Research Methodology**

This chapter explains ethnography as a suitable methodological approach to conduct this research. Because ethnography provides the opportunity to the researcher to address the interaction, contextual and issues of power in the therapeutic relationship with a close reading of context. To identify the objectives of this study, reading the context carefully is essential. Chapter three provides details of the justification regarding the selection of ethnography for this research and general issues associated with ethnography and what steps were taken to rectify these issues. This chapter discusses the philosophical stance of this research. Critical realism was selected as the philosophical stance of this research. Chapter 3 describe how critical realist stance enables the researcher to adopt an abductive reasoning analysis for this study. Explains the inclusion of elements of Fairclough's Critical Discourse Analysis (CDA) and its suitability to combine with the ethnography to analyse this thesis. Also, discuss the role of pragmatism in this study.

### **Chapter 4: Research Method**

This chapter explains how this study conducted based on the methodologies and theories explained in chapter 3. The subjects discussed in this chapter include details of study design, study settings, methods adopted to tackle the ethical issues of this study, study samples, participant recruitment, demographic details of the participant, data collection, reflection on ethical approval process and data collection how to organise and analyse the data, the steps and the methods adopted to ensure rigour in this research.

### **Chapter 5: Introduction to the Findings**

This chapter briefly summarises the themes and subthemes arises from the analysis of data collected from the first and second stage. The following three chapters will discuss the themes and subthemes in detail.

### **Chapter 6: Compliance and Therapeutic Relationship**

This chapter explains how patient compliance and non-compliance influence in creating therapeutic relationship in three sections. Initially, the relationship between patient compliance and therapeutic relationship explored on the basis of previous literature. Secondly, this chapter includes the analysis section. The analysis mainly looks into the interactional strategies and the involvement of contextual factors and the underlying power mechanism in the compliance and non-compliance conversation and how it influences the therapeutic relationship. At the interactional level, the analysis looked at how compliance and non-compliance are managed in the interaction and the interactional strategies positively or negatively influence in creating the therapeutic relationship. For example, what are the strategies used by the therapist to handle the patient illustrate the non-compliance with the treatment regimen and how these strategies influence in creating the therapeutic relationship. Also, contextual factors and mechanism of power involved are included in the analysis. The overall, findings related to compliance and therapeutic relationship are summarised in the third section of this chapter.

### **Chapter 7: Solidarity and Therapeutic Relationship**

This chapter explains how the solidarity-related conversations influenced creating the therapeutic relationship in three sections. Initially, the previous literature that describes the relevance of solidarity in health professional-patient



interaction is discussed. Secondly, this chapter includes the analysis section. The analysis mainly looks into the interactional strategies and the involvement of contextual factors and the underlying power mechanism involved in solidarity forming conversation and how it influences the therapeutic relationship. In the interactional level, the analysis looked at how the patient and therapist illustrate solidarity each other by using different interactional strategies and how these strategies help to enhance the therapeutic relationship. Also, the chapter explores the associated contextual factors and the type of power mechanisms that involved in those solidarity interactions. The third section is a synthesis of the overall findings of the chapter based on Fairclough's Critical discourse analysis.

### **Chapter 8: Expectation and the therapeutic relationship**

This chapter explains the interactional features, the contextual factors and the the associated power mechanism in the matter of patient expectation and how it is associated with the therapeutic relationship in Indian outpatient physiotherapeutic settings. Similar to the other two findings chapter 8 is comprised of three sections. The first section includes the previous literature that explored the link between patient expectation and the therapeutic relationship. The second section is the analytical part use sample extracts to analyse. The analysis look at the role of expectation in therapeutic relationship in its interactional and contextual level as well as examine the involvement of power relationship. The third section presents a synthesis of the overall findings related to patient expectation and the therapeutic relationship.

### **Chapter 9: Discussion and Conclusion**

The discussion chapter is comprised of four parts. The first part includes the discussion on the theory and models emerge from the findings of this study and

compare the findings of this study with the findings of previous literature. The second part discusses the implications and future recommendations for practice and research. The third section discusses the strength and limitation of this study. Finally, this chapter includes the thesis conclusion.

#### **1.4 Summary of this chapter**

This chapter provided an introduction to the entire thesis including the justification, actual contribution of knowledge, about therapeutic relationship, the involvement and importance of certain elements in identifying the social process of therapeutic relationship, the objective of this study, the researcher context and the summary of each chapter included in the research. The next chapter will provide the detailed review about the previous literature in the field of physiotherapy that especially explored the contextual, interactional elements and the issues of power associated with the therapeutic relationship that briefly discussed in this chapter. The Indian health care systems, the history of physiotherapy as a profession in India and the current issues associated with Indian physiotherapy will also be discussed.

## **Chapter 2: Background and Literature Review.**

### **2.1 Chapter introduction:**

This chapter is comprised of three sections. The first section includes the review of the previous literature that explored the therapeutic interaction and the issues of power related to the therapeutic interaction. Secondly, the chapter provides descriptions about the socio-cultural context and health care systems in India, the history of the physiotherapy profession and present issues associated with the Indian physiotherapy context. The final section includes the reasons for conducting this research and the objectives of this research.

### **2.2 Therapeutic relationship and previous research**

Abundant research has been conducted regarding the impact of the therapeutic relationship in health care (Crepeau & Garren, 2011; Kidd et al., 2011; Hall et al., 2012). Many of those studies identified the use of language in patient-therapist interaction as an important factor in the underlying social phenomena of the therapeutic relationship. In physiotherapy, only a limited number of studies have explored the therapeutic relationship by using linguistic features of therapeutic interaction (Parry, 2004; Talvitie & Pyoria, 2009 ; Parry, 2009). All of these studies were conducted in the developed country. Most of the studies were conducted to find out the connection between the therapeutic relationship and treatment outcome. For instance, patient-therapist relationship in physical

therapy settings were linked with reduced pain and reduced disability (Hush, 2011). They also identified how the therapeutic relationship was linked with satisfaction or explored different factors in the clinical context associated with the therapeutic relationship. The majority of such studies were from the context of developed countries. Certain studies especially in the field of psychology, general medicine and nursing identified the importance of exploring power in the therapeutic relationship and examined the nature of the power or power dynamics that existed in therapeutic relationships.

In the field of physiotherapy, Williams and Harrison's (1999) study was the first published article that reviewed the issues of power in the therapeutic relationship, but later very little literature included issues of power in the patient-therapist relationship. The following section reviews the literature in physiotherapy that especially focused on the linguistic, contextual and power issues in the therapeutic relationship.

### **2.2.1. Patient-therapist interaction**

The way the therapist and patient interact with each other in a medical setting greatly influences the therapeutic relationship (Greenhalgh & Heath, 2010). According to Crepeau and Garren (2011), to develop a strong therapeutic relationship, the therapist must be able to interact in a way that allows them to enter into the patient's experience, connect with their emotional feelings, and be willing to modify their perspective in order to respond to the patient's needs. Therapeutic interactions, like almost all social interactions, are not only multi-layered but also multi-faceted and as such, they can be examined in numerous ways (Wodak, 1997). However, based on its structure, function and context the therapeutic interaction is certainly different from ordinary everyday conversation

(Josephson & Bulow, 2014). Physiotherapy interactions are rich in communication about bodily matters, topics clearly central to many health care interactions (Josephson & Bulow, 2014).

According to the literature there are a number of factors associated with a successful patient-therapist interaction. Those factors can mainly be categorised into three: interpersonal (related to patient and /or therapist), clinical/organisational and wider socio-cultural elements (Kefee et al., 2016).

Therapist professional and personal characteristics were found to be the major interpersonal elements that contribute to successful therapeutic interaction. Confidence, knowledge, skill and the ability to teach or provide information to the patient in an appropriate manner were frequently mentioned as the professional characteristics of the therapists that enhance positive therapeutic interaction (Kids et al., 2011; Hills & Kitchen 2007a; May, 2001; Cooper et al., 2011). For instance, adequate knowledge of the therapist helps the patient to take proper decisions about a treatment plan by providing evidence based information during the discussion of their decision making process. This kind of knowledge transformation will help to form a healthy partnership between patient and therapist. Appropriate knowledge of the therapist will also help to provide an adequate answer to the patient's questions and explanations regarding the patient's current problem. This increases the confidence and motivation of the patient. A confident and motivated patient will comply with the treatment regimen. Perceived therapists' personal characteristics such as warmth, caring, empathy, friendliness, respect, ability to motivate patients and ability to relate are the personal characteristics of the therapist that enhance their treatment outcome and satisfaction (May, 2001; Hills & Kitchen, 2007a). Patients perceived that therapist personal characteristics like friendliness encourage them to interact

openly with their therapist. This enables the therapist to achieve more information related to patient health condition, social situation and their need. This, in turn, helps the therapist to take a decision about an appropriate treatment for the patient or to reach an accurate diagnosis/prognosis. Therapist professional characteristics such as confidence and skill found to enhance patient trust on therapist.

Patient active participation and expectation are the factors that most influence in effective therapeutic interaction. According to Talvitie and Pyoria (2006) patients' active participation is essential for a successful healthcare interaction and it influences their satisfaction with that care. Hush (2011) systematic review found that satisfied patients are more likely to be compliant with treatment strategies, attain more successful treatment outcomes and have a higher quality of life. The study of Hills and Kitchen (2007b) explained that patient expectation was a factor that possibly influences the therapeutic interaction. Patients with an acute condition or those who had no previous physiotherapy experience has less expectation than chronic patients or the patients who had previous experience (Hills & Kitchen, 2007a). So, if a patient had an expectation about a specific treatment that had been beneficial previously, but did not receive that treatment because of insufficient opportunity to discuss the possible treatment options (Hills & Kitchen, 2007a), then this negatively influenced the therapeutic interaction (Hills & Kitchen, 2007a).

In the past two decades studies related to therapeutic interactions in rehabilitation settings have explored two different aspects: the micro/ interactional or the macro level / social-cultural contextual factors; in which majority of the studies focused on the micro- level interactional features. Such studies explore the micro level interactional patterns or strategies that emerge from therapeutic

interaction and have a significant role to enhance patient outcome (Parry, 2004; Parry, 2009; Thomson, 2008; Josephson & Bulow, 2014; Talvitie & Pyoria, 2006). In this case a successful / clinical interaction are identified as the specific interaction strategies between patient and therapist that would improve the patient outcome. Physiotherapy is theoretically closely aligned with the biomedical framework (Parry, 2004). Therefore, the physiotherapist tends to focus on disease, symptoms and performance rather than on patients actual needs. Parry (2004) identified that as a result of therapist's excessive focus on the patient's physical performance could not allow her to pay attention on patient's real concern. In many situations a social interaction enables health professionals' to find out more information about patients' social situation and this will help to choose appropriate treatment for the patient based on their needs. Social interaction is a way to diminish social distance between health professional and the patient and allows the patient opportunities to share power; thereby, enhance patient participation. Generally, patient participation improves quality of life and provides an increased sense of ownership and management of one's symptoms, illness and circumstances, and gives people a sense of control and self-determination (Parry, 2004).

Timely explanations, negotiations with patients, and critical reflection are identified as the interactional strategies that enhance positive interaction between patients – therapeutic. However, ignorance and resistance is a barrier to creating a positive therapeutic interaction and patient outcome. In addition, incongruence between the therapist's perspective and patient expectations is a barrier for effective communication (Talvitie & Pyoria, 2006). The study of Talvitie and Pyoria (2006) identified such kind of incongruence occurred as the result of

lack of joint understanding between the patient, and therapist. They suggested the need to develop dialogical communication skills of the therapist.

Clinical/ organisational factors especially, related to the structure, procedures and environment of the health care settings were found to possess a key role in effective therapeutic interaction (May, 2001; Hills & Kitchen 2007; Cooper et al., 2008). Empirical studies identified that flexible appointment systems, less waiting time, confidentiality and having enough time with the therapist are the major concerns perceived by patients (May, 2001; Hills & Kitchen 2007a; Cooper et al., 2008). Calm and quiet atmosphere, quick and direct access to service and privacy were found as the environmental factors that influence therapeutic interaction (May, 2001; Hills & Kitchen 2007a; Cooper et al., 2008; Williams & Harrison, 2000).

For instance, the lack of sound privacy. Patients perceived that because of partitioning by use of curtains between consultation cubicles, was felt to them as a major cause of embarrassment and disempowerment (Williams & Harrison; 2000).

A very limited number of studies identified socio cultural factors such as belief and gender as the factors that influence therapeutic interaction and patient outcome in physiotherapy settings. For instance, a study conducted in India identified that female patients appeared passive and submissive during their physiotherapy consultation (Marwaha, Horbin & Mclean, 2010). This is because of the Purdha system offered only less power to them in the society.

This study will analyse the different element such as individual, clinical as well as the wider socio- cultural factors influence to create a successful therapeutic interaction. In addition, how the underlying mechanism of power is linked with all these factors while a patient and therapist interact each other in the outpatient



Indian physiotherapy settings. The interpersonal factors in the therapeutic interaction will be investigated by looking at the the interactional strategies of patient and therapists, especially the ways in which those strategies enable both the patient and therapist to handle the different situation and how it positively or negatively influences the therapeutic encounter. This study will also identify the possible clinical (institutional) as well as the wider socio-cultural factors associated with the interactional strategies. By looking at those contextual factors this study will aiming to focus on how and why such contextual factors lead to the production of such interactional strategies.

### **2.2.2 Power and status of the health care professionals**

Power is more often perceived as a quantifiable thing that “tends to be associated with rank and status” (Thornborrow, 2002). Certain individuals may have more of it than others; that is, certain people are more powerful than others. For instance, in the international context of politics, the American president is generally seen as more powerful than a president of a small nation. Or in sociology, males are generally considered as having more power than females (Thornborrow, 2002). Within institutional discourse it is also natural to view certain members as more powerful than others.

The nature of the healer-patient relationship changed throughout history (Burke, 2008). The nature of the therapeutic relationship is highly dependent on the social role of the professionals in that society (Banerjee & Sanyal, 2012). In the early centuries, from the fifteenth to the nineteenth centuries medicine was treated more like a trade than a profession (Burke, 2008). Patients from higher social classes might treat the doctor as a superior type of servant. From the nineteenth century onwards as a result of the growth in science, medicine and

institutionalised education, the formation of policies and the presence of published textbooks marked changes to the medical profession were made (Burke, 2008). This, in turn, changed the social importance and professional status of the medical professionals and they achieved a higher status in society (Burke, 2008).

In the early 1950s Talcot Parsons, a sociologist, investigated the social structure of the therapeutic relationship (Burke, 2008). In that era all health professionals, including physiotherapist had a great deal of power (Illich, 1975). In contrast, patients in that period took a passive 'sick role' and lacked any autonomy, remaining "defenceless" (Burke, 2008). Therefore, health professionals maintained a professional distance from the individual patient in order to correctly interpret the signs of disease, an act in which the patient played no part other than as the site of that disease (Eisenberg, 2012).

However, Ian Kennedy's Reith lectures in the 1980s called for a new relationship between doctor and patient. According to his point of view, the patient should take more responsibilities for their lives (Burke, 2008). Nowadays, in developed countries, health care practices are based on the patient-centred model in which treatment is provided to the individual patient on the basis of preferences, needs, and values, and ensuring that patient values guide all clinical decisions. Patient-centred care is typically based on the therapeutic relationship and it gives equal power to both patients and clinicians (Burke, 2008). In the present situation, rapid social changes and a lot of advances in medical technology are happening in developing countries. These changes can influence the power relationship between the patient and health professionals in health care settings of developing countries (Banerjee & Sanyal, 2012). So this study also gives an opportunity to learn about the existence of power in therapeutic

relationship in the clinical and the socio-cultural context of developing countries like India (Banerjee & Sanyal, 2012). The Figure: 2:1. on next page Illustrate the different form of power possessed by the patient and the health professionals in the different era in the society.

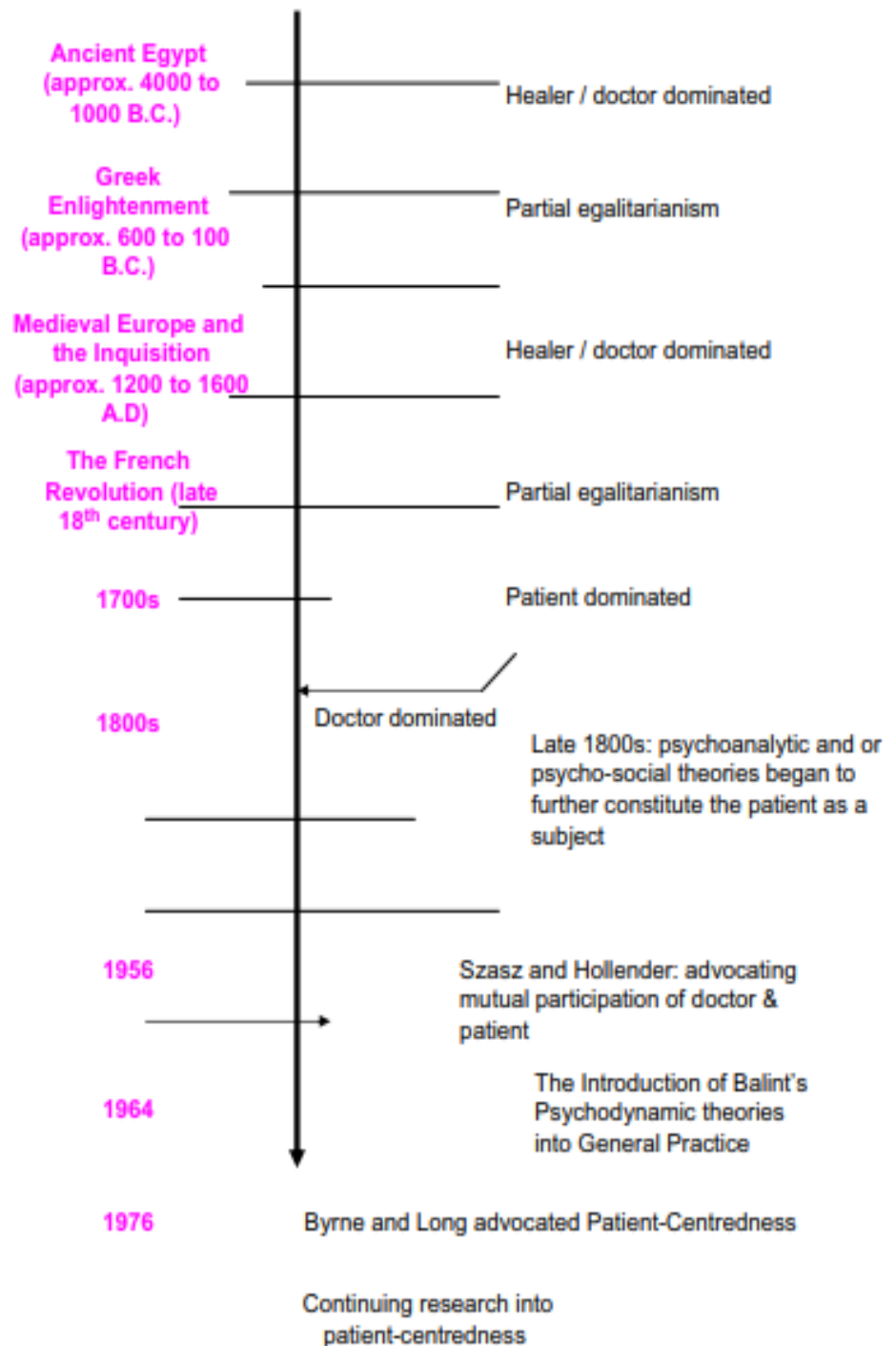


Figure: 2:1. The different form of power possessed by the patient and the health professionals in the different era in the society. This figure adopted from the study of Kaba and Sooriyakumaran (2007).

### **2.2.3 Power and therapeutic interaction**

Since the 1960s growing concern about 'effective' communication in healthcare settings has resulted in research that focuses on power and domination in the medical encounter. Previous studies have been mainly empirical or descriptive and were weakly grounded in theory. However, a limited number of studies explored power in clinical interactions and I will review these in this section. In addition, the relative scarcity of physiotherapy related research in this area has led to include the review of certain literature from related professions.

Parry (2009) theorised power as a persuasive force and the study analyses how such power enables the therapist to foster mutuality, provide education and minimise resistance through the physiotherapist act of account (explanation) while they interact with the patient. Parry (2009) analysed 41 video-recordings of neurological physiotherapy treatment by using conversational analysis. The study found that timely production of an account is likely to increase the therapist's persuasive force. The persuasiveness of account sequences is also increased when the patient prompts (or actively involved) the therapist in the conversational situation. However, the lack of participation of the patient in therapeutic conversation was found as the leading cause of infrequent accounts from therapist and it possibly affects the therapeutic relationship in a negative way (Parry, 2009). But, Parry's (2009) study did not explore when and why clinicians invoke persuasion associated with particular matters within accounts. In Harrison and Williams (2000) study power dynamic illustrated as an active and constantly changing one. Power depending upon context, value and previous experience (Harrison & Williams, 2000). Based on Harrison and Williams (2000)

view in therapeutic relationship the interactional power does not lie solely with the therapist; patients also hold power, but to a lesser extent than the therapist. In addition, the environmental factors such as confidentiality and intimate place are also play an important role in exert power in therapeutic interaction (Harrison & Williams, 2000).

Harrison and Williams (2000) study analysed 10 audiotaped in-depth semi-structured interviews of both patient and therapist from an outpatient musculoskeletal physiotherapy unit. The patient perceived the therapist's personality was a major factor related to their power in institutional setting. In the previous session it was discussed that many of the previous physiotherapy empirical studies perceived patients personal or professional characteristics of physiotherapist as a factor of successful interaction. However, in Harrison and Williams (2000) patients perceived that such power had the potential to be either supportive or facilitative, or to be dominating and restrictive. In therapist based power, physiotherapists perceived their power differentials relating to their expert status and role. Therapists perceived patient power based are overt dominant like patient aggressiveness. For instance, patient's aggressive behaviour related to symptom tolerance. However, patients perceived they possessed very low power base, especially in terms of decision making. Both patient and therapist perceived that the clinical outpatient environment is disempowering for the patient. Also, patients perceived the therapists time pressure as a lack of interest of therapist in themselves. Consequently, they felt unvalued and powerless. Harrison and Williams (2000) study found that there is a mismatch of perceptions between therapists and patients in their interactional power. However, the study didn't find out or discussed why such difference occurs in patient and therapist perception.

Nimmon and Hayes (2016) explored how power is perceived and exerted in the physician-patient encounter from the perspective of experienced physicians by using Bourdieu's concepts of power that is ascribed by the social institution. This study also utilized Bourdieu's habitus and doxa concept to explore the power in therapeutic interaction. Habitus, is described as a set of learned dispositions and inclines individuals to act and react in certain ways (based on their working context). Habitus is based on experiences; it ensures the active presence of previous experiences found in every organism as perception, thought and behaviour schemes, for instance how an individual behaves based on their previous experience in a particular institutional context like medical context. Doxa further elaborates his notion of habitus, and is used to make sense of how physicians subconsciously accept and internalize attitudes, knowledge, beliefs and values of the institutional and organizational culture of medicine without knowing they are doing so.

Nimmon and Hayes (2016) conducted semi-structured interview to collect data from a minimum of five years' experience physicians working in the different disciplines of medicine. In those, some of the physicians participated in this study identified themselves as a powerful person because of their possessed knowledge and authority in the field of medicine. Because of this they perceived that they have an inherent responsibility to act in the patient's best interest by managing their position of power with integrity. This will enable them to achieve and maintain patient's trust. Therapist described that providing information to the patient and involve them in the decision making (power sharing) is an example of how therapist manage their power in a positive way.

Some of the physiotherapy participants found their power in therapeutic interaction is diminished in the context of changing health care. The healthcare

culture which encourages consumerism or patient rights leads to a power struggle in the therapeutic encounter.

However, a group of therapists in Nimmon and Hayes (2016) study identified power is irrelevant in the context of physician-patient interactions or they perceived power is dissolving through friendly relationship with patients. From the basis of the findings Nimmon and Hayes (2016) suggests that it is important to make sense of this lack of reflection of physician power as part a process that develops and (re)structures medical student habitus through contact with the broader institutional and organisational culture of medicine or to make sense of the subconscious socialisation process that does not traditionally involve discussions or considerations of one's position of power within the healthcare profession hierarchy. However, Bourdieu's notion of habitus and doxa is incapable of explaining the variance of power because not only the the medical habitus but also the individual factors, such as values, tastes, beliefs and preferences play a crucial role in shaping the power in therapeutic interaction. Therefore, Nimmon and Hayes (2016) recommend to explore the individual aspects of power relationship by investigating language strategies.

Baptista et al. (2017) study analysed the discourse of hospitalized patients regarding nursing care relations by using theoretical concepts of Michel Foucault. This study analysed audio-recorded semi structured interview of 16 patients hospitalized in medical and surgical clinics of a university hospital in Brazil. During the analysis this study made use of the discourse of patients as the main means for obtaining the information and for its capacity to reveal the experience and the history of each patient admitted at the hospital. Then, an inter-relation was made between the proposed system (health care) and the elements found in the patients' speeches.

While investigating the interrelationship based on the Foucault concept this study essentially considered three main points; first the scenario in which the actions take place, that is, if this scenario is governed by norms and routines, which by themselves constitute a form of action on the action of others that are inserted in this context; the second point is associated with the subject and the meaning that is attributed to the given relation; and the third point refers to the reading and interpretation that this subject makes of the posture or actions employed by the other in the dynamics of the relationship.

The results showed that the professionals exert power by the highly specialized professional knowledge and that they know what they do, so they send and control the accomplishment of the care, leading the patient to submission. It concludes that the exercise of the power to care must be based on the observance of ethical and bioethical principles.

Foucault work in particular has popularized a different understanding of power as a ubiquitous property of the technologies which structure modern institutions, not possessed by or attached to any particular social class, stratum or group (Foucault, 1979). That is Foucault not tied the ideology with power. Foucault focused on the interface between discourses, power and knowledge. Fairclough argue that this sense of Foucault's power has displaced the former, more traditional one, and more importantly has helped divert attention from the analysis of power asymmetries and relations of domination. According to Fairclough to understand the real world of social relationship in institutional practice, it is essential to consider ideology. For instance, the pronoun we is in the clinical context, typically used to deictically refer to the in group of the current speaker. In theory, and depending on context, any variable structure of language may be ideologically marked (Fairclough, 2001). Another example is gender



relation, gender as a social category and it may intersects with age or class. In this kind of situations the concepts of ideology that opposed by Foucault consider the gender relations without attention to their functioning within the social system (that is how gender intersects with age class or ethnicity, etc.).

Above literature explored both the negative and positive aspects of institutional power. Parry (2009) and Baptista et al. (2017) focused on how the therapists handle power while they interact with their patients. Especially, how the therapists utilized their power of knowledge and information to handle their patient during therapeutic interaction. Harrison & Williams, (2000) argued not only the therapist but also the patient hold power to a certain extent. So, while exploring power in therapeutic interaction it is also essential to consider the power issues associated with the patients. In addition, Harrison and Williams, (2000) identified the immediate environment as a factor that influenced interactional power. However, Nimmon and Hayes (2016) found the necessity to consider the wider cultural factors associated with therapeutic interaction. For instance, how consumerist approach influence on therapeutic interaction. However, none of these studies explored the patient, therapist, clinical and the wider sociocultural factors in a single study. So, it is relevant to investigate how such elements associated with therapeutic interaction in a single study.

Based on the above reviewed literature power is dynamic, it present in both macro aspect of interaction as well as the macro level of context. However, none of the studies explored why the power mechanics exists the way it does. Certain studies like Nimmon and Hayes (2016), Harrison and Williams (2000) only explored how the health professionals or / and patient perceived the concepts of power and not explored why the power mechanism perceived in the way that presented by the physician. In addition Bourdieu's notion of habitus does

not provide space to Nimmon and Hayes (2016) to consider the individual factors such as the belief, value or expectation play in shaping power in therapeutic interaction. However, Parry (2009) only focused on micro aspects of power in therapeutic interaction using conversational analysis. Nimmon and Hayes (2016) and William and Harrison (2000) basically focused on power manipulated within the institutional system and those studies failed to make a connection with wider socio-cultural aspect. That's what saw in Baptista et al. (2017) study; the Foucault concept focused only on institutional based knowledge and power.

Therefore, it is relevant to create a methodological framework that enables to explore how and why the power forms and emerge in a therapeutic interaction in various situation by considering both the micro as well as the macro aspects of it. That is, power is explored both in terms of as an asymmetries between participants in discourse event and in terms of unequal capacity to control how text (interaction) are produced , distributed and consumed in particular socio cultural context. While investigating the interactional asymmetries a range of properties of the text (eg. turn taking, assumptions/ presuppositions) were analyse how it potential link with ideologies. That is, in short this study will look at how and why the combination of the institutional power as well as the power ascribed from the society possessed by the therapist and the patient produce interactional events in an institutional setting.

Chapter 3 will describe the different elements of critical realism, ethnography and Fairclough's critical discourse analysis utilize this study to develop a methodological framework that explores the power involved in therapeutic interaction in its interactional (micro) as well as the institutional and the wider socio- cultural (macro) level .

## 2.3 Indian socio-cultural context and health care systems

### 2.3.1 Indian socio-cultural context

India is a South Asian country and its geographical location is in the figure (2:2).



Figure 2:2: Indian Map that highlighting the different states of India (Access from the Maps of India website. Retrieved from [www.mapsofindia.com/maps/india/india-political-map.htm](http://www.mapsofindia.com/maps/india/india-political-map.htm))

India is comprised of 29 states and seven union territories with more than 22 official languages. According to the 2017 revision of world population prospectus 1.34 billion people were lived in India which is 17.6% of the entire world population (United Nations, 2017). India has a fast-growing economy (OECD, 2017). However, over a third of the population live on less than US\$1.25 per day (United Nations, 2017). According to the World Bank reviewed and proposed revisions in May 2014, 20.5 % of the world's extremely poor population is from India (The World Bank Group, 2014). The thirty-two percentage of the Indian

population live in urban areas (WHO, 2013). The 65% of the population in India is under the age of 35 (WHO, 2015). The mean life expectancy is 68.35 years, which is lowest when it compare to UK, the mean life expectancy of UK is 81. 60 (WHO, 2015).

The socio-cultural background of the Indian population is diverse, mainly in religion, language, food, education and social status (WHO, 2015). Religious practices and beliefs are one of the most notable aspects of diversity in the Indian population. Hinduism, Islamism, Christianity, Sikhism, Buddhism and Jainism are the main religions practised in India (Sharma, 2015), with more than three-quarters of the population being Hindu (Sharma, 2015). Even though the Government of India (2011) considered 22 languages as official, actually there are more than 122 languages spoken by people living in India (Sharma, 2015). However, each states in India have their own official Language. For instance, the official language of Kerala is Malayalam.

Traditionally Indian society is defined by the social hierarchy system, which is called the 'Caste System' (Luke & Munshi, 2007). 'Caste system' is a kind of social stratification in which the social classes are defined by thousands of hierarchical groups (Kapoor, Kshatriya & Kapoor, 2003). The 'caste' and its effect were projected in different sectors in Indian population including the health care system. For example, the treatment choices could differ across castes due to differences in health beliefs and practices, discrimination by the health care providers (Luke & Munshi, 2007). The lower castes in society were historically relegated to unskilled occupations and faced severe social discrimination (Luke & Munshi, 2007). Although the government of India has taken several steps to remedy these inequities still a large caste-gap in education and income continues

to be observed in both rural and urban India today, over 60 years after independence (Luke & Munshi, 2007).

### **2.3.2 Health care system in India**

India's health care system is characterised by multiple systems of medicine, mixed ownership patterns and different kinds of delivery structures. Health care is delivered in India through public and private health sectors. The private health sector is the dominant health sector throughout India, between 70% and 80% of total health care spending in India is in the private sector (OECD, 2017). Both health care sectors provide various types of health service which include Ayurvedic, Unani, Siddha and Homeopathy which are traditional medicines, but the majority being western allopathic. There are 6.5 doctors, 10 nurses and an estimated 2.5 physiotherapists per 10,000 of the Indian population (WHO 2015; Grafton, 2013).

#### **2.3.2.1 Public health care sectors**

The public sector ownership is divided between Central & State governments. At the central level, it is governed by the 'Ministry of Health and Family Welfare, India and at the state level by the 'State Ministry of Health and Family Welfare'. At the state level, it is divided again by municipals and panchayath (local governments). This level is headed by the secretary of health and the technical wing consists of civil servants and medical doctors. The majority of patients attending the public sector are from the population below poverty level. Below Poverty Level (BPL) is an economic benchmark used by the Indian Government to represent people from low socioeconomic status. In the public sector, the treatment is free for the patient from BPL.

Health care services in public health sectors are organised at three levels: primary, secondary and tertiary health care (Kandaswamy, 2012). The primary level of health services is providing through village teams, Sub-centres (SCs) and Primary Health Centres (PHCs). The Community Health Centres (CHCs), Sub-District Hospitals (SDH), District Hospitals (DH) and dispensaries make up the secondary level, and the teaching hospitals provide health care at the tertiary level (Kandaswamy, 2012). Physiotherapy is mainly available only in teaching hospitals in the public sector. However, some secondary level hospitals also provide temporary physiotherapy units in public sectors.

#### **2.3.2.2 Private health care sector:**

This sector is comprised of profit and non-profit organisations (Kandaswamy, 2012). The profit sector of private health care is comprised of many institutions and types of practitioners. The profit sector provides services through big super speciality hospitals, multi-speciality hospitals, clinics, polyclinics, dispensaries, physiotherapy clinics, diagnostic centres, medical centres and private teaching hospitals (medical colleges). The major portion of health services is delivered through the profit sectors, whose number of institutions exceeds the public sector organisations. There are numerous nursing homes and outpatient clinics that deliver the health service in profit sector (Kandaswamy, 2012).

The non-profit sector consists of non-governmental organisations (NGO), missions, charity organisations, trusts etcetera. Among non-profit sector, a number of NGO (Non-Government Organisations; organisations that are neither a part of a government nor a conventional for non-profit business) provides effective services and are growing over the years in their service delivery

(Kandaswamy, 2012). However, they are very less in number compared to the profit sectors (Kandaswamy, 2012). Moreover, informal health sectors (these are the sectors where people without professional qualification are providing health delivery and they are faith healers) includes priests, traditional birth attendants and local medicine person are also present (Kandaswamy, 2012).

In India almost all health care professionals such as doctors, dentist, nurses, and pharmacist have their own regulatory bodies both at the state and central level, those regulatory bodies termed as councils. Councils provide licence to professionals to practice and also for professional growth (Kandaswamy, 2012). However, physiotherapists, occupational therapists, laboratory workers and other 'para-medical' professionals have no councils at present in India to regulate and provide growth to the profession and professionals.

#### **2.4 History of Indian physiotherapy and current issues**

Physiotherapy came to India just after the Second World War, mainly through colonial and charitable routes (Kale, 2003; Premkumar, 2010). British authorities first imported physiotherapist from the UK to British India for the rehabilitation of handicapped in the 1940s. In addition to that in the 1940s occupational centres and an artificial limb making centre were established in Poona for the rehabilitation of injured veterans from the war. In 1947 a society for the rehabilitation of crippled children in Bombay was created and this society organised a physiotherapy and rehabilitation clinic for the treatment of those suffering from infantile paralysis and other forms of crippling diseases (Shimpi et al., 2009). This organisation took the major role in 1952 following an epidemic of poliomyelitis with the help of the trained physiotherapists in India (Shimpi et al., 2009).

In addition to that, Leprosy sanatoriums started in the 1950s took a major role in the development of the physiotherapy profession in India (Premkumar, 2010). Leprosy is an infectious skin and nerve disease that can spread due to close and repeated contact from nose and mouth droplets (WHO, 2017). In mid-20<sup>th</sup> Century, these leprosy sanatoriums were started for the rehabilitation of people with leprosy, where people were provided with physiotherapy training to rehabilitate the patient (Shimpi et al., 2009). In short the Second World War, leprosy centres and the eradication of polio in the 1940s and 1950s lead to the entry of the physiotherapy profession in India (Shimpi et al., 2009; Premkumar, 2010).

In India initially, physiotherapists practised passive movement, active movement technique and massage techniques that were practised in the UK in the 1940s. A training school of physiotherapy have been first organised in KEM Hospital, Mumbai and in the 1970s introduced physiotherapy diploma courses in India (Shimpi et al., 2009). Two decades after the introduction of diploma courses; in the early 1990s, Bachelors in Physiotherapy (BPT) course was introduced in India at *Aligarh Muslim University*. Later in 1998, Jamia Hamdard University took the lead in starting the post-graduate course in Physiotherapy in north India (Wikipedia, 2017a). In south India the Christian Medical College, Vellore was the first institution formed for physiotherapy; they first introduced a certificate course in physiotherapy, then diploma courses graduation and post-graduation (Wikipedia, 2017a). At present, 250 colleges offer the undergraduate program, more than 50 colleges offer masters and a few universities offer PhD in India (IAP 2017). A rapid increase in the number of colleges providing physiotherapy courses was found in recent times from 52 in 1999 to 205 in 2004, an increase of more than 25% in five years (Daker-White et al., 1999). However, to ensure the



quality of physiotherapy education, the necessity to contextualize the education according to the India's need, focuses on research are identified as some of the significant challenges that phasing the Indian physiotherapy educational system at present (Grafton, 2013 ).

The drive for this increase is likely consequent on economic advancement from recent industrialisation (Reddy et al., 2011) enabling more technologically advanced and in specialised health care for at least a proportion of the population. Moreover, as a result of globalisation much opportunities to travel and work abroad permit the advancement of higher education sector within Indian, even though India's health care system struggles to meet the need of its population (Peters, 2002).

In clinical aspects, the new affordability of private health care for rapidly expanding middle-class populations in India has caused them to emulate health care practices already established in better resourced areas of the world (Turner, 2007), and has led to the further development of the physiotherapy profession in India.

However, in the present situation, the physiotherapy profession in India is facing a lot of issues for its further development from different aspects that include social, cultural, professional and political aspects. Some of these important issues related to the growth of the physiotherapy profession in an Indian context will be discussed in the following section.

### **1) Issues associate with the professional regulation**

Even though the physiotherapy profession reached India through British colonization, there are present differences in the structure between India and the UK. A profession is defined by the state as well as the place of its position relative

to other professions (Freidson, 2001). Medicine, as the profession from which it emerged, forms a key comparator for physiotherapy. Indeed in India, regulatory control is exerted, not by the government, but by the medical profession. Because of this, today physiotherapy in India is still dominated by medical doctors who continue to prescribe physiotherapy treatments (Grafton, 2013).

The important reason behind the domination of medical professionals is related to the definition of "physiotherapy" that was provided by Ministry of Health and Family Welfare in India. According to that definition, physiotherapy means medically directed therapy, including heat, cold, light, water, massage, electricity or manual exercises to persons with the aim of preventing or correcting any disability (Government of India, 2008). The term 'medically directed' in the definition stating that physiotherapists are the paramedical technical staff who are trained to assist a doctor or work under the guidance of the doctor (Government of India, 2008). So the use of 'medically directed' in the definition does not allow autonomy to the physiotherapy profession.

Several times the Indian Association of Physiotherapy (the existing governing body of physiotherapists in India) has approached the authorities to eliminate the phrase 'under the medical direction' from the definition of physiotherapy and put a lot of effort to form an independent council for physiotherapist (Selvam, 2010). However, these attempts have been unsuccessful. The government highlighted the reason for their decision as for lack of regulation of the standards and inadequate quality of the education and training system in several physiotherapy institutions (Grafton, 2013). This kind of justification from the side of Indian government pointed towards the ability of the Medical Council of India (MCI) to arrange a quality regulatory system (Grafton, 2013). The MCI, the regulatory body which is responsible for maintaining the

high and uniform standard of all Indian medical education system, was temporarily disbanded in 2010 being alleged with corruption after its president was arrested by the Central Bureau of Investigation (Horobin, 2016). Followed by this incident several corruption controversies related to MCI came out. On the basis of these controversies, the Indian government decided to permanently disband MCI with a new medical commission named as National Medical Commission. For that government position a new bill went before parliament in 2016. However, several protests were formed in the country against this decision of the government. These events illustrate an inadequate level of functioning in professional governance in the uppermost level of professional practice in India and created a chaotic atmosphere for professional growth. In summary, any additional form of autonomy of practice for Indian physiotherapist will continue to be obstructed due to the absence of government action to introduce a greater level of professional independence for physiotherapists.

## **2) Issues related to Indian Association of Physiotherapy (IAP): Split in IAP**

A registered national association for physiotherapist is present in India, which is called the Indian Association of Physiotherapists. This was founded in 1955, and at present more than 30,000 physiotherapists are members of this body (IAP, 2015). Documents of World Confederation for Physiotherapy (WCPT) illustrated that from 1967 onwards Indian Association of Physiotherapy (IAP) was a member of WCPT (Grafton, 2013). However, in March 2015 the membership was terminated by the Executive Committee of WCPT (WCPT, 2016). The reason for the termination stated that the Indian Association of Physiotherapists had not paid the membership subscription for several years. The conflict inside the IAP was the real cause behind the unpaid subscription fee.

The IAP 's body is controlled by the board of elected office bearers, which included President, Secretary, Treasurer and various convenors to monitor various activities of the IAP (IAP, 2016). All members are elected by the membership which occurs every three years. After the 2011 election, the IAP divided into two because of some election related issues between the long standing president Dr Ali Irani and the newly elected president Dr Umasankar Mohanty. In the present situation, there is two IAP (Grafton, 2013). One division is led by Ali Irani and the other one is led by Umasankar Mohanty. Each group has their own websites, but they resemble each other in structure and function, and they each appear to claim the full membership complement and to be operating on the same membership list (Grafton, 2013). After this split, none of these associations paid the yearly membership subscription fee. WCPT (2015) reported that because of the split in IAP this made confusion about whom to send a paper regarding the issues related to the payment of the subscription. That ended in the termination of membership. Many Indian physiotherapists agree that the split is harmful to Indian physiotherapy development at a time when they are seeking a regulatory council and professional practice autonomy (Grafton, 2013).

Because of these issues, each state in India, of which there are 29 and 7 union territories, started to form their own councils in the state level and some of the states such as Maharashtra, Gujarat, Delhi and Tamilnadu form their own separate councils (IAP, 2015). However, many states including Kerala, Telangana are still struggling for forming a state level council. The physiotherapist's association in the Kerala state started their legal fight to form a state council 8 years ago. In 2017 the Honourable High Court of Kerala heard the petition submitted by Kerala Association of Physiotherapist Co-ordination (KAPC) and directed the government of Kerala to take appropriate decision to

regulate the physiotherapy profession in Kerala after considering the views of all stakeholders. However, the initial report created by the government of Kerala to High Court of Kerala in this issue was not supported to form a council of physiotherapy in Kerala. One of the main reasons mentioned that the financial burden to create a council for physiotherapist in Kerala (Government of Kerala, 2018). Also, the Government fear that if the physiotherapy council forms, in future the similar urge from all most all other nearby 50 paramedical professions (Government of Kerala, 2018).

### **3) Protection of title**

In India, the duration of basic physiotherapy bachelor degree qualification is four and half years. In addition to that, certain institutions provide a two year diploma course in physiotherapy. At present, in India, there is no physiotherapy assistant post. So without enough educational background, these diploma holders worked under the title of physiotherapists. Otherwise, many employers in the Indian health care system recruited diploma holders for physiotherapist post. In recent years IAP and state level physiotherapy associations strictly warned employers that for physiotherapist post only to recruit persons who successfully completed four year physiotherapy degree and six month internship (Grafton, 2013). However, different state physiotherapy associations still identified that many unapproved (all the colleges in India need affiliation from a University Grants Commission accredited University) physiotherapy colleges are still conducting physiotherapy courses in different states of India (IAP, 2016). So, it is acknowledged that significant challenges remain to contextualise the profession to India's needs and to ensure quality across educational institutions (Grafton 2013 ; Swaminathan & D'Souza, 2011).

#### 4) **Autonomy**

The global picture on physiotherapy autonomy in practice is mixed (Grafton, 2013). In the case of developed countries such as UK, USA, Canada, Australia and New Zealand there is some form of statutory professional regulation with the protection of title (Grafton, 2013). However, in India, many physiotherapists are struggling for their autonomy. The practice of physiotherapy as a first contact profession is not common in India (Horobin, 2016). That is physiotherapists often mainly depend on referrals from physicians from the different fields of practice of medicine. They were unable to utilise the defined body of knowledge that is owned by the 'profession' and they must follow doctors' orders (Horobin, 2016). Often, there has been no opportunity for negotiation around their role to enable them to implement practice according to their set of professional values.

In addition to that in many multispecialty, super speciality private hospitals and government district hospitals there is a category of specialised medical doctors called physiatrist (Medical doctors specialised in physical medicine and rehabilitation). They are strongly against the autonomy of physiotherapists in India. Physiatrists usually stand between the physiotherapist and specialised doctors (for example, orthopaedic neurology, and cardiology etcetera). For instance, an orthopaedic doctor first refers a physiotherapy treatment needed patients to the physiatrist and the physiatrist will prescribe the mode of physiotherapy treatment. Then they send these patients to a physiotherapist. So basically these professionals further restrict the autonomy of physiotherapists and under the supervision of physiatrist, a physiotherapist is forced to work as a technician to obey the physiatrist choice of treatment. Therefore, the existence of the physiatrist post, in both private and public sectors, affected the status and autonomy of the physiotherapist. So to improve the status, professional

standards and autonomy of the physiotherapist in health care sector it is essential to implement certain rules and regulations that protect or raise the professional status and autonomy of physiotherapy.

### **5) Status of physiotherapy**

A characteristic of any profession is that it occupies a social standing relative to other professions (Whitfield et al., 1996) and the prestige of occupation is determined by the members' access to 'wider bases of social power' (Johnson, 1977). Several studies provide information concerning the prestige of physiotherapy in various countries. It is argued that the history of physiotherapy in developed countries is the history of a middle class feminine. Feminine professions are less powerful than masculine professions because of patriarchy (Allan et al., 1996). Short et al. (1986) described that physiotherapists have better working conditions and levels of pay than nurses initially in developed countries because physiotherapy is considered as a predominantly middle class profession whilst nursing draws its recruits mainly from the working class. Also, physiotherapists enjoyed higher occupational prestige than social workers, speech therapists and occupational therapist (Johnson, 1977) in the UK like other developed countries.

The changing social, political and cultural factors in a country will have a greater influence in determining the social status and power of a profession. In India, all medically related professions enjoy a relatively high status (Gokhale & Sasidharan, 2012) which makes them an attractive career choice. However, unlike developed countries due to the absence of proper laws and regulatory systems, the physiotherapy profession is not getting its appropriate recognition in India presently (Horobin, 2016). Like other professions initially, physiotherapy

was a male dominated profession in India. But the rapid social changes have brought some new freedoms for women. These developments support the career aspirations of a newly emerging, majority female and middle class health professional (Horobin, 2016).

Physiotherapists in India use the title 'Doctor' and prefix it before their name with a suffix P.T. (Physiotherapist) ; so as to make their stand clear that they are not medical doctors (Grafton, 2013). The kind of title people use in a hierarchal society have an important role in determining their status. In this way, it can be argued that to obtain the "titled Dr" is a way to achieve higher social status in the society (Grafton, 2013). Physiotherapy professionals in India still worried about their role in the health care settings and status in the society. So maybe this is the reason the physiotherapist used the "title Dr" by themselves.

However, the use of the title 'Dr' according to the IAP is by tradition and convention (Grafton, 2013). Physiotherapists argue that they are not breaching any law prevailing in India as legally only one who has earned a degree in medicine (medical doctorate) or PhD is justified to use and prefix the 'Doctor' title (Grafton, 2013). However, this has become a controversial issue among physiotherapist and medical doctors.

It was suggested that the importance of salary levels was particularly important in Indian culture and an individual's position in the hierarchy (Grafton, 2013). Salary is a factor that determines the status of occupation. An interesting fact about physiotherapist salary status in India was discussed by Sinha (2011). The study of Sinha (2011) identified that an inverse relationship between qualification and pays for Indian physiotherapist. Sinha (2011) demonstrated a descending path of physiotherapists pay relative to doctors and dentists, and the



subsequent alignment with other 'paramedicals' who had a much lower entry level qualification in his study. Also, the article illustrated the evidence that in the 1960's physiotherapists and doctors were on identical salaries. However, It was argued that since the 1980's the Indian pay commission had systematically set out to 'degrade and devalue' physiotherapists despite their increased academic status (Sinha, 2011). This change in pay scale assumes to put the physiotherapist in a lower position in the social hierarchical system than before (Sinha, 2011).

## **6) Public attitude and awareness**

India is a country that is well-known for its cultural, traditional and ethnical diversity. Mostly the Indian population believes in traditional forms of treatments and home based remedies with rich ancestral values (SivaKumar, 2015). A culture with such a strongly influencing traditional code for its health management could not easily accept the entry of a totally different form of treatment base. For instance, a strong faith in Ayurvedic medicine prevails in the general public (Khare, 1996). Ayurvedic medicine is the first option for the majority of the population in India especially for musculoskeletal problems. Many of those patients come to a physiotherapist pretty late when orthopaedics or other doctors refer them to physiotherapist after the condition worsens. In these cases, the difference in patient and therapist believes can also create disjuncture's in the understanding of health between physiotherapists and their clients, whose understanding of ill health may be far from scientific (Grafton, 2013).

The majority of the Indian population are from lower middle class and low socio- economic class. These people depend on government hospitals for their treatments. However, a lack of government initiatives is widely apparent to implement physiotherapy departments in government hospitals. Because of this

most of the patients from lower middle class and low social class cannot access the physiotherapy treatment from government hospitals for free. These patients cannot afford the private hospital fees. This, in turn, leads to the situation where the patients self-treat their condition through traditional Ayurvedic medicine or Nattu Vaidyan (Ayurvedic mal-practitioners) for their rehabilitation. Even the existing government hospitals are also providing low quality physiotherapy treatment because of the inadequate patient-therapist ratio or doctors not referring the patient to physiotherapy department because of the inadequate number of physiotherapist to treat the patients. Government actions through appointing the adequate number of the therapist in government hospitals and introduce new physiotherapy units in more government hospitals would help to increase the awareness about physiotherapy among low socio-economic groups, who represent more than a quarter of the Indian population.

## **7) Static practice**

The future of Indian physiotherapy profession depends on the skills of the present students studying physiotherapy in India, where the profession is still in its infancy (Naik & Naik, 2015). That means Indian physiotherapy practice has remained comparatively static with treatment similar to those initially transferred there in the 1950s (Naik & Naik, 2015). For example electrotherapy for the treatment of musculoskeletal problems; the emphasis is on electrotherapy modalities, such as hot and cold, ultrasound, interferential, shortwave diathermy and transcutaneous electrical nerve stimulation (TENS) or other passive modalities, such as traction, and general exercises, such as strengthening (May, 2010). However, the use of electrotherapy in the UK was reduced over the last thirty years (Horobin, 2016). The socio-political variations in the UK have affected the change in practice (Horobin, 2016). One of the changes includes the

introduction and development of manual therapy techniques, such as the Maitland approach (Ottosson, 2011). The emergence of such practices leads in time to the decline of electrotherapy (Horobin, 2016).

In India, there is the only limited introduction to manual therapy on most courses, but many therapists who are interested undertake short manual therapy courses at a postgraduate level (May, 2001 ). These are either run by Indian therapists who have worked in Australia or the UK or more recently there has been a growth in officially organised courses by different manual therapy organisations.

#### **8) Quality and the accessibility issues related to physiotherapy in public health care sector.**

Public health care sectors have high relevance in a developing country like India in order to extend healthcare to vast sections of under-served populations. The number of hospitals that provide physiotherapy are limited in India, especially in rural areas. According to the 2011 survey among 120 core population 83.3 core population in India live in rural area. So, this negatively influences the ability of the rural population to access physiotherapy treatment. The crisis of Indian public health care system is always a popular topic of discussion among the citizens, the politician, health care professionals and policy makers nationally and internationally. Previous literature identified that low quality of care, high absentees and low satisfaction with care and amenities, and rampant corruption are the main factors that act as the barrier of the development of public health care system (Hammer, Aiyer & Samaji, 2007). According to Hammer, Aiyer and Samaji (2007) the Indian policy makers failure to hear, recognise and take action on what people want, as well as the politician's failure to transmit the requirement

of the population to the public health care providers are the major reasons behind the crisis. Lack of high quality research that addresses the issues in public health care system is also recognised to affect the growth of public health care system. All these identified elements negatively influence the growth and delivery of physiotherapy care in the public health care system. An inadequate number of physiotherapists recruited in the public sector also acts as the barrier to improve the quality of physiotherapy care (Grafton, 2013). For example, in the state of Kerala public sector had not increased the number of physiotherapists employed in last 10 years. That is, the last recruitment of physiotherapists via public service commission was conducted a decade ago.

## **2.5 The reason for this research**

From the reviewed studies in section 2.2 it is clear that the interactional features, contextual factors and power issues have a great influence on therapeutic relationship in physiotherapy settings. Several studies based on patient-therapist interaction or therapeutic relationship have focused solely on the interactional features or contextual factors or issues of power (Parry, 2004; Talvitie & Pyoria; 2006; Parry, 2009). None of the previous literature conducted the analyses of the social aspects of patient-therapist relationship by exploring the interactional features, the power relationship and contextual variables in altogether.

Moreover, all those reviewed studies conducted in the context of western countries. The rapid socio-cultural changes that are happening in developing countries will reflect on different aspects of the health care system (Harrison & Williams, 2000). Many of the present issues in physiotherapy profession that discussed in section 2.3 could be the result of the rapidly changing socio-cultural

situations in India. Possibly those changes have an influence on different aspects of physiotherapy practice.

As described in 2.3 India is one of the most diverse nations in the world in terms of religion, caste, language, culture, ethnicity, geographic condition and socioeconomic status. In many ways, this diversity impacts health care interaction. The cultural beliefs, attitudes and values are the most notable aspects of this diversity. The lack of awareness of the patient's cultural belief, values and attitudes increases social distance, impairs communication, and precipitates misconceptions between patients and their healthcare providers (May & Potia, 2013). This possibly influences the therapeutic relationship. For instance, physiotherapy considered as Western based model of practice. But, India has its own traditional medicine system, called ayurvedha. Many patients in India choose ayurvedha as their first option, especially for their musculoskeletal condition (Nisula, 2006). Most of the treatments in ayurvedha provide passive form of treatments like oil massage, diet, external and internal application of herbal medicines etc. However, physiotherapy encourages the patient to take the active role in their life mostly through exercises and functional training. In India majority of the patients attend the physiotherapy through physician referral. So, in this situation, it is significant to look at how the physiotherapist, the representative of western medicine handles the referred patient, who had previous experience or belief in Indian traditional medicine. This, in turn, helps physiotherapist to build a culturally adaptive strategy to enhance the engagement with physiotherapy.

In India, all medically related professions enjoy a relatively high status (Gokhale & Sasidharan, 2012). However, unlike in developed countries due to the absence of proper laws and regulatory systems, the physiotherapy profession is not getting its appropriate recognition in India presently (Horobin, 2016). In this

situation, the physiotherapists in India are struggling to get an acceptance in Indian society, especially in terms of their social status.

Within the institution, the higher power possessed by the medical doctors enable them to exert direct or indirect control over the other medical professionals including physiotherapists. In India, the doctor's control over the physiotherapist is relatively higher than that of western countries. Lack of properly ascribed roles and responsibilities of physiotherapist within the organization may be one of the main reasons for this higher control. According to the physiotherapists in India, medical doctors do not allow them to exert their medical power as an expert in the clinical setting (Grafton, 2013), especially, in terms of conducting independent assessments and suggesting treatment. In the current situation Indian physiotherapists are struggling to get an acceptance both in institutional as well in the societal level. So, in this situation, it is relevant to know how the therapists handle their power while interacting with the patients and its impact on their therapeutic relationship. This helps to build strategies to improve the therapeutic relationship and thereby to improve the patient outcome.

Therefore, exploring the various aspects of (interactional, contextual factor and power issues) the therapeutic relationship in a different clinical and cultural context of Indian outpatient physiotherapy settings is a relevant topic for this research. So this study is an attempt to investigate the interactional features, the power relationship and the contextual variables and their interplay in making the patient-therapist relationship in physiotherapy outpatient setting of a developing country like India.

## **2.6 Objectives**

- To identify the involvement of power in patient-therapist relationships in an Indian outpatient physiotherapy setting.
- To understand the patient-therapist interactional strategies and how it influence in creating therapeutic relationship in an Indian outpatient physiotherapy settings.
- To identify the institutional and societal contextual elements that are associated with the therapeutic-relationship in an Indian outpatient physiotherapy setting.

## **2.7 Chapter summary**

This chapter provides an outline of the therapeutic relationship; the importance of socio-cultural context and discourse in the therapeutic relationship; the interplay of power relationship and power dynamics in the therapeutic interaction, and general features of medical discourse. The chapter also outlined the socio-cultural context of Indian health care, the historical context, present issues about the Indian physiotherapy context, and justifications for this study and the different objectives of this research. The next chapter will describe the adopted methodology and its philosophical underpinning that was used to address the objectives of this research.

# Chapter: 3 Research Methodology

## 3.1 Chapter introduction

This chapter explains the methodological aspects of this thesis. A qualitative research design was selected as a methodology for this study. From different types of qualitative research designs ethnographically guided qualitative methodology was considered as suitable to investigate the particular objectives of this research, which were to identify textual, contextual and power issues associated with the therapeutic relationship (Hamersely & Atkinson, 2007). So this chapter explores in detailed the ethnographic methodology, its philosophical evolution and its relevance to this research. Furthermore, it provides the description and justification about the selection of ethnographic tools to collect data, critical discourse analysis (CDA) as a tool to analyse the data and the role of speech act theory to analyse the textual aspect of this study.

## 3.2 Ethnography:

Ethnography was developed by anthropologists in the late nineteenth and early twentieth centuries for the study of small-scale, traditional, isolated societies, although it is now widely used by practitioners of many disciplines in all kinds of research settings (Angrosino, 2007). Ethnography is a plan of action or strategy of investigation in which the researcher studies an intact cultural group over a prolonged period of time in a naturalistic setting to understand research problems on the basis of how people's values and beliefs direct their actions (Crede & Borrego, 2013). There are two main types of ethnography: focused ethnography and anthropologic ethnography. Anthropologic ethnography is the traditional ethnography. However, focused ethnography varies from conventional ethnography because its aim to study a small group or culture inside an



organisation, such as, a clinic, hospital or healthcare unit (Savage, 2006). The focused ethnographic approach is used in this research.

Focused ethnography has been used in health care research for more than 50 years (Savage, 2006). Savage (2006) pointed out that focused ethnography is useful in health care settings to explore a vast number of topics, especially issues about professional client interactions or relationships. Focused ethnography is also called mini or micro-ethnography (Roper & Shapira, 2000). In recent years health care research focused ethnography has been widely used because of its relevance and usefulness in health care practice and in making health care policies. Also, it is identified as an important methodology to recognise the effect and influence of being or part of the culture of clinical practice

This study selected focused ethnography because it allowed the researcher to conduct the investigation in a closed organisational setting like a health care systems as per the research objectives. In anthropologic ethnographic tradition, the researcher sometimes spends several years in the field. However, in focused ethnography, the researcher is able to do the investigation in a shorter time period.

### **3.2.1 Conceptual underpinnings and rationale behind the selection of ethnography**

Each and every individual has their own cultural identity (Spradly, 2016). Individuals within the same cultural identity hold common characteristics such as languages, practices, customs, values and views. Individual cultural identity reflects through social behaviour, which influences the interactions among them. Ethnographers are interested in investigating how individual's behaviour impact on or are mediated by the culture in which they live (Parahoo, 2014). So

ethnographers explore the meaning that participants make in their life. Subjects express these meanings through verbal and nonverbal cues such as, different postures and gestures, daily routine practice, the way of addressing each other, style of greeting, and talking and interacting with each other in various circumstances.

Hammersley (2006) explains that the main advantages of ethnography are based precisely on the grounds that it is able to get closer to social reality than other methods. For instance, in contrast to phenomenology, ethnography allows the researcher to investigate how and why people behave the way they do instead of relying only on what they say. Through participant observation and interviews, an ethnographic research methodology enables the researcher to recognise the behaviour of the people in their social environments, the bonds that the people develop with each other and the ways in which they attend to these relationships, and the use of different interactional strategies to manage different situations (Whitehead, 2005).

Being in the cultural setting means the researcher has adequate flexibility to ask questions and identify problems that arise while observing the individual in their cultural surrounding. In the first stage of my data collection, the informal conversations with the participants and the semi-structured interviews in the second stage provided me with an opportunity to clarify any doubts and allowed me to discuss observations with participants. This approach helped to provide richness in the explanation about how and why human behaviour exists the way it does in this particular setting (Charmaz, 2006).

Ethnography can be taken as a theoretical perspective that focuses on the concept of culture and its relation to observed behaviour. According to Maxwell (2012), culture cannot be reduced to the individual's behaviour, lifestyle or

thoughts or subsumed in the social structure. In other words, culture is a phenomenon, which comprises of both symbolic-meaningful (ie part of the mental rather than physical perspective) and collective (that is, the property of groups rather than of single individuals) domains (Maxwell, 2012). That is the casual mechanism underpinning the reality of the social phenomena interrelated with both behaviour and social structure. Smith and Elger (1997) pointed out that, social structures such as, class, gender, or race have causal powers over actors. The institutional contexts also have powers over the actors. So, not only actors' behavioural or interactional features can be interpreted, but also how the different form of power possessed by the actor's acts upon their interaction.

According to Hammersely and Atkinson, (2007) compared to other qualitative research methods, ethnography helps the researcher to achieve insight into the issues that immediately are not visible like power relationships. This is possible through the direct entrance of the researcher into the research setting. In my study it is essential to identify how the combination of institutional power and the power ascribed by the society is involved in the patient- therapist interaction. The power relationship is established or reinforced through language. So, in the first stage of data collection through participant observation ethnography enabled me to directly capture the original textual conversation between patient and therapist from the natural hospital settings. In this way, the ethnographic method helped to investigate the phenomena at its micro level (analyse discourse at the textual level). Also, a proper understanding of discourse requires investigating the institutional contexts in which it is produced (Hammersley, 2006). Ethnography enables the researcher to spend time in the research settings which helps the researcher to collect the contextual information both in the institutional as well as in its wider socio-cultural aspects. So, the eight

weeks that I spent in the institutional setting in each stage of this research allowed me to be immersed in the research context. This, in turn, helped to collect the significant clinical and the socio-cultural contextual information to interpret the discourse produced by the patient and therapist. In this way, ethnography captured the macro (contextual factors based on institutional and wider socio-cultural issues) level information associated with the patient-therapist relationship in the Indian physiotherapy institutional settings. Therefore, in total, participant observation and semi-structured interviews used in different stages of this research helped to achieve the objective of this research by capturing the social phenomena of therapeutic relationship in a multidimensional way.

According to Maxwell (2012) culture is a complex term and is difficult to define. Most disciplines recognise culture to be values or beliefs shared by members of a community or social group (Maxwell, 2012). So, interpretation of these values or beliefs has a key role in the ethnographic study. The interpretation depends on the perspective of the researcher. Therefore, it is relevant to know whether the researcher is a member of the culture being studied or not. In this study, the researcher herself belongs to the community that is being studied. According to Hammersely and Atkinson (2007), cultural insider or a native researcher rather than a foreign researcher to the region can know the source of cultural meaning more easily.

### **3.3 Philosophical framework: The research paradigm**

Before discussing the philosophical underpinning of this research, it is essential to explain the word paradigm. The word paradigm comes from '*The Structure of Scientific Revolutions*' (Kuhn, 1962), however, the book did not provide any satisfactory meaning of the word 'paradigm' (Morgan, 2007). Later the meaning of the word 'paradigm' was discussed broadly by different authors

and its variant meanings are now a central concept in scholarly work (Patton, 1982; Chalmers, 1982; Schwandt, 1989). For example, Patton (1982) referred to paradigms as frameworks for thinking about research design, measurement, analysis, and personal involvement whereas Schwandt (1989) referred to paradigms as “worldviews” and beliefs about the nature of reality, knowledge, and values. If the paradigm is considered as a worldview, every paradigm is based upon its own ontological and epistemological assumptions (Scotland, 2012). Since all assumptions are conjecture, the philosophical underpinnings of each paradigm can never be empirically proven or disproven (Scotland, 2012). Different paradigms have different ontological and epistemological stances; therefore, they have differing assumptions about reality and knowledge which underpin their particular research approach. This is reflected in their methodology and methods. In this sense positivism for quantitative research was the first dominant paradigm that originated from the mid-19<sup>th</sup> century (Guba & Lincoln, 1985). Positivist’s stance is for discovering absolute knowledge about an objective reality (Scotland, 2012). Positivists use hypothesis driven methodology (Scotland, 2012). From the beginning of the twentieth century, positivism faced its first challenge, as a result of which qualitative research was derived with an underpinning paradigm of constructivism or interpretivism (Crotty, 1998). Constructivists or interpretivists argue that the subjective reality cannot be measured directly, only perceived by people, they view it through the lens of their prior experience, knowledge, and expectations (Crotty, 1998). Later in the 20<sup>th</sup>-century, post-positivism or critical realism emerged from positivism as an alternative paradigm (Creswell, 2013).

### **3.3.1 Critical realism:**

Critical realism was considered as an anti-positivist movement in social research closely associated with the works of Roy Basker and emerged in the 1970s and 1980s. Roy Baker's critical realism was further expanded by a number of other critical realists, such as, Sayer (1992), Archer (1995), Collier (1994) and Lawson (1997) (Danermark et al., 2002). Critical realism was considered as a scientific alternative to both constructivism and positivism (Fletcher, 2017). This was not associated with the Frankfurt school of critical theory; however, a certain form of social criticism is used here and there in the works of critical realism. Critical realist is aligned with positivist in certain aspects (Danermark et al., 2002). That is the critical realist support the positivist thought that there is a world of the event out there that is observable and independent of human consciousness (Basker, 2009). Critical realists also believe that knowledge of this world is socially constructed and society is constructed through human beings emotion, thinking, feeling and interpretation of the world must be studied (Basker, 2009). Critical realists considered that reality is arranged in levels and this will be explained the later section of the chapter (Fletcher, 2017).

### **Rationale behind the critical realist perspective of this study**

This study does not just identify the discourse that is produced in the physiotherapy settings but also identifies why (the underlying causal mechanism) certain discourses are used, the impact of these discourses and can map the context in which discourses are used to reflect particular constructs of reality. This is possible through the critical realist open system perceptive (Basker, 2008).

According to Basker (2008), in the absence of spontaneously occurring, and given the impossibility of artificially creating, closed systems, the human sciences must confront the problem of the direct scientific study of phenomena that only

manifest themselves in open systems. In an open system generative mechanisms become more contingent and indeterminate; that is the unobservable causal mechanism interact in contingent and indeterminate ways to produce change at the level of observable events. So, it is necessary to look more expansively and exhaustively in the search for causative agents. Critical realist perspective enables us to consider how physiotherapy practice operates in an open system.

Based on Basker's concept, the patient and therapist in a physiotherapy open system possessed a combination of institutional power and a power ascribed by the society (Fairclough, 2003). According to Basker (1976), all the entities (objects, individual or structure) in the open system possess causal powers. So, when a patient and therapist in a physiotherapy setting interact with each other it means their power interacts. When the power interacts it generate a given set of events. This combination of power act during their interaction may or may not be easily observable at the empirical level (Fairclough, 2003). This is known as the 'epistemological fallacy' (described in section 3:3:2) (Basker, 2008). According to Basker (1976) the 'epistemological fallacy' can be resolved if the researcher attempts a deeper analysis that can support, elaborate, or deny that theory to help build a new and more accurate explanation of reality. Critical realism believes science is explanatory, not simply descriptive (Basker, 2008). This concept is essential when a study requires something beyond the storytelling (Wynn & Williams, 2012). The aim of this study is to explore why the patient-therapist relationship in the Indian physiotherapy settings exists in the way it does rather than solely provide a thick description of participant perspective about therapeutic relationship. So the explanatory concept will help to achieve the aim of this study.

The explanation can be achieved with reference to Basker's concept of 'stratified ontology' (described in the section 3:3:2) (Basker, 2008). The 'stratified ontology' concept of critical realism enables the researcher to see the world as a multidimensional system and to approach the underlying reality from multiple viewpoints in order to overcome the perceptual limitations (Wynn & Williams, 2012). In this way, the critical realist advocates a multi-level approach to causal analysis and helps to provide multiple possible explanations of an event occur in therapeutic interaction (Wynn & Williams, 2012). This way of thought also encourages an interdisciplinary approach to the study and hence includes discourse analysis to solve the problem of the physiotherapy setting.

### **3.3.2 Ontology and epistemological issues.**

As mentioned above critical realism was formed as an alternative to both constructivism and positivism. However, in ontological and epistemological stances, critical realism took the elements of both approaches (Fletcher, 2017). As a philosophy of science critical realism is a methodological framework for research that is not related to any specific kind of method (Fletcher, 2017). Critical realist believes that ontology is not reducible to epistemology. That is the nature of reality is not reducible to our knowledge of reality (Fletcher, 2017). The knowledge of human beings is able to capture only a small amount of vaster and deeper reality (Denzin & Lincoln, 2011). In this aspect, critical realism diverges from both positivism and constructivism. Basker (2009) opposed positivists for encouraging 'epistemistemic fallacy', that is, problematic reduction of ontology to epistemology. In other words the limitation of reality to what can be empirically known (Fletcher, 2017). In the case of constructivist, they belief that reality as totally constructed through and within human knowledge or discourse (Fletcher, 2017). Here, from a critical realist view, both constructivist and positivist reduces



the reality to human knowledge if that knowledge is performed as a lens or container of reality (Fletcher, 2017). Critical realists treat the world as theory-laden, but not theory-determined (Fletcher, 2017). The critical realist never rejects the social world that everybody can try to know or access through the philosophy of science, however, they believe that certain knowledge may be nearer to the reality than other knowledge (Fletcher, 2017).

Roy Basker stratified the critical realist's ontology into three different domains; this is explained by using the 'iceberg' concept (figure 3:1) (Fletcher, 2017). The different domains are the *Real*, the *Actual* and the *Empirical* (Nellhaus, 2010). The fundamental domain is the *Real*. All the real entities (object or social structures) in nature possess causal power and susceptibilities which affect and are affected by other entities. That is if something has the causal power it is *Real* (Fletcher, 2017). When these entities interact they produce events (Nellhaus, 2010). That is, the *Actual* refers to what happens when these causal powers and susceptibilities are activated or produce change. The *Empirical* domain is considered as the level of experience (Nellhaus, 2010) - some fraction of events are, or result in, experiences or concepts (Fletcher, 2017). *Empirical* experiences or concepts can influence behaviour. This is the transitive domain of reality, where actions, meanings, decisions and social ideas occur, which can themselves be causal (Fletcher, 2017). The language and other semiotic structures or systems are dependent on actors for their reproduction, they already pre-exist any given actor or the subset of actors and have relative autonomy from them as the real object even when not actualised (Nellhaus, 2010).

On the basis of the critical realists ontological position, the primary aim of the critical realist is to explain social events or processes with reference to the causal mechanisms and the effects they have throughout the three-layered

'iceberg' of reality (Fletcher, 2017). The iceberg representation is not meant to suggest that the three domains do not interact or that any one domain is more or less '*Real*'. Certainly, all three domain of the iceberg is the part of the same entity (Fletcher, 2017).

As mentioned above critical realists believe that life is an open system in which all events are governed by causal power (Nellhaus, 2010). An object or the social structure possesses inherent potentiality that enables or compel it to perform in a certain way (Fletcher, 2017).

Various circumstances in the open social system can facilitate or prevent the actualization of structure's causal power, which may or may not be observable at the empirical domain (Nellhaus, 2010). Because of this, the process of reproduction examines specific social conditions under which a causal mechanism takes effect in the world (Fletcher, 2017).

The next section will explain how the level of real, actual and empirical linked with the objective of this study.

Power: According to the objective of this research, the power related matters in the therapeutic interaction may be belong to the level of real. Because power is always considered as an element that submerged in the society or it can not easily observable. For instance, usually, it may not be easy to visible the underlying mechanism of patient non- compliance to the treatment at the level of empirical. So, to identify the underlying mechanism of this, it is essential to look at the power possessed by the individuals at the institutional level and the individual's causal power that ascribed by the societal structure. It will in, turn, helps to identify how the combination of these power work in that situation.

Interactional features: Interactional features belong to the level of either empirical or actual. According to this study while patient and therapist interact each other the combination of these power possessed by both parties (patient and therapist) create an event. For instance, patients express their resistance indirectly to the treatment program, which may not be observable. This represents the level of actual. However, in certain situations, the interactional features can be interpreted as directly observable events at the level of empirical level. For instance, patient direct resistance.

Contextual factors: Interactional features belong to the level of either empirical or actual. In certain situation the contextual factors that can be easily visible or interested in the immediate context of patient – therapist interaction. It possibly projects in patient and the therapist interaction at its empirical level. For instance, patient accessibility; that is, patient may be expressed accessibility issue as a reason for non- compliance. However, some of the contextual factors cannot be observable at the level of empirical. For example, patient’s age related attitude towards compliance.

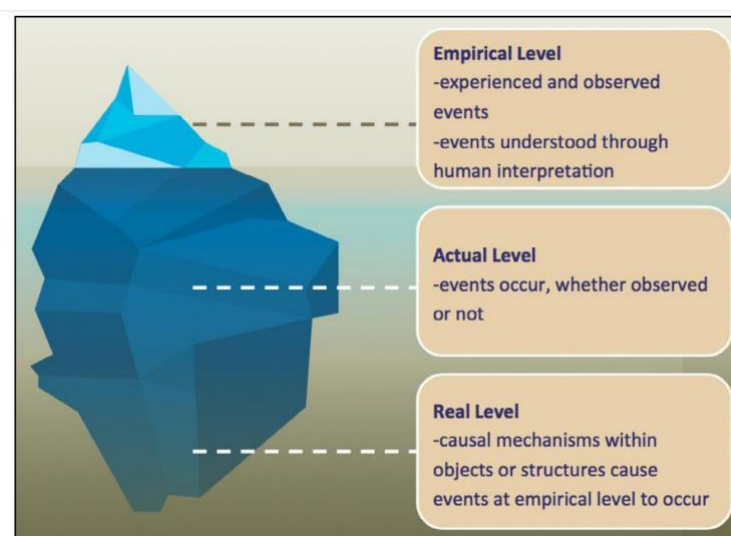


Figure: 3:1: Critical realist ontological explanation using 'Iceberg' Image. This figure adopted from Fletcher (2017).

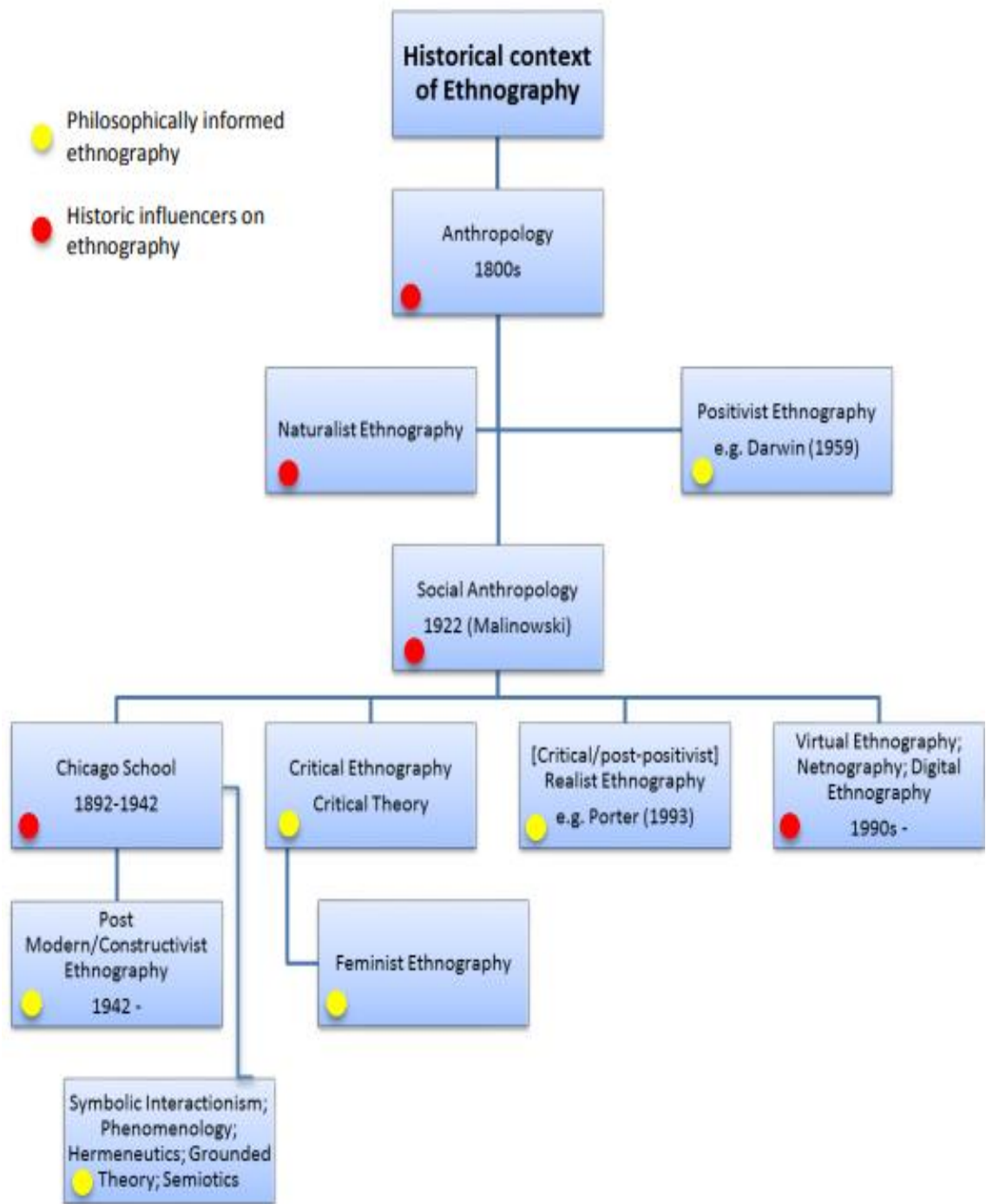
### **3.3.3 Critical realist ethnography**

There are different debates among researchers regarding the different aspects of ethnographic research, in which one of the most important existing debates is what is and what is not ethnography (Sinead, 2017). In these arguments, some ethnographers claim that ethnography is holistic and needs to describe the findings with respect to its macro level (Herbert, 2000). However, others have encouraged the micro-ethnography approach (Herbert, 2000). Nowadays, there have been attempts to study both micro and macro levels of the social phenomena by combining the ethnographic approach with specific research paradigm like critical realism (Sinead, 2017).

Ethnography originated from early anthropology in the 1800s. Later on different kinds of philosophical paradigms have been used or incorporated with ethnographic approaches including positivist ethnography, critical ethnography, critical realist ethnography (CRE) and post-modern/constructivist ethnography (Figure 3: 2) (Sinead, 2017). Constructivism is an approach commonly used in the ethnographic study. However, this approach values the 'thick description' of communities and cultures and the perspectives and experiences of participants. It has been criticised for subjectivity and the risk of bias (Sinead, 2017). Critical realist ethnography may be appropriate when a study requires going beyond telling stories, taking behavioural observations and perceptions of participants at face value (Sinead, 2017). In a constructivist or positivist standpoint, traditional ethnographic methods can never go into sufficient depth to explain why a culture and associated behaviours exist (Danermark et al., 2002). Porter (1993) and Sharpe (2005) proposed that critical realist ethnography considers the micro level (the individual) and acknowledges how this fits into a macro (wider/social) context, but also seeks to explain why the phenomenon being studied behaves

in the way it does. Critical realist ethnography starts in the same place as more traditional methods, with the perceptions and experiences of individuals, but uses this as a starting point for further enquiry through observation, theory and evidence. This means it can negotiate the conflict between positivist and constructivist ethnographic approaches by using the constructivist emphasis on subjective meaning, and the structure and rigour of their methods.

When considering the critical theorist's ethnography, it does not provide an opportunity to the researcher to identify possible underlying power structures. So, from the above descriptions, it is considered that critical ethnography is suitable to investigate the objectives of this research.



**Figure: 3:2** Different types of the ethnographic approach based on its philosophical underpinning (Adopted from Sinead, 2017).

### **3.4 Issues associated with ethnography**

#### **3.4.1 Objectivity and selectivity:**

Like all qualitative research approaches ethnography is also associated with certain issues, which need to be taken into consideration. Objectivity is claimed as one of those issues associated with the ethnographic study because it is argued that ethnography is mostly dependent on the personal experiences of the researcher. This, in turn, leads to the possibility to shift the focus of ethnographic study from participants to the researcher. In order to reduce the effect of the researcher in ethnographic research, the researcher always ensures to provide priorities on subject's thoughts, feelings and experiences above his or her own (Lietz, Langer & Furman, 2006). The presence of the researcher in the research setting may influence the participant interactions, behaviour or responses. This, in turn, affects the natural occurrences of events. To tackle this issue in this research the researcher herself was immersed in the research setting for a period of time, which helped to develop trust with the participants of the research. It is believed that by spending a long time in the research setting the researcher is more likely to be considered an insider (Parahoo, 2014). However, Hammersley and Atkinson (2007) mentioned that too close rapport with the study subjects may lose the objectivity to some extent. Also, it is essential to consider the researcher regarding the chance of losing objectivity while working in a familiar settings. So, it is essential to take the preparations to tackle this issue. Constant reflexivity of the researcher is identified as one of the ways to tackle this kind of problem (section 4.7.2 further discuss about this).

Ethnography can be considered an interpretation of culture. So the cultural identity of the researcher with respect to the culture being studied is an important

matter in ethnographic research. The researcher perspective will influence the knowledge produced about the cultural group. Discussion on the advantages and disadvantages of the insider and outsider status of the researcher, and its influence on the research have been contentious in ethnographic studies (Hammersley, 2006).

There are no overwhelming advantage or disadvantage to being an insider or outsider (Hamersely & Atkinson, 2007). Each perspective has its own merit and demerit, but these may be slightly varied in its weight and depend on the particular circumstances and purpose of the research. There are various strategies to increase the validation of the research. For instance, simultaneous collection and analysis of data in field research and constant reflexivity are considered ways to control the researcher impact on researcher data. In order to get more credible information while working in the research setting the researcher always took certain steps to avoid manipulating a subject's perceptions of the research topic or their knowledge of it (Silverman, 2013). The strategies adopted to increase the credibility of this study are explained later in this chapter (see section 4:9).

### **3.4.2 Time-consuming approach**

Ethnographic research is considered as a time-consuming approach (Hamersely & Atkinson, 2007). An ideal length of time in the field is difficult to establish. Earlier anthropologic ethnography research rural cultures had an ideal of twelve months minimum in order to study the annual cycle of the growing season (Roper & Shapira, 2000). This kind of fieldwork took place over a long period of time, at least a year and often several years (Roper & Shapira, 2000). By contrast, much of what is referred to as ethnography in the different disciplines



today does not meet one or more of the criteria built into the anthropological definition. Instead, many ethnographers focus on what happens in a particular work locale or social institution when it is in operation so that in this sense their participant observation is part-time (Roper & Shapira, 2000). Many researchers argued that it will raise some issues that are quite important (Hammersley, 2006). The researchers, sometimes tend to treat people as if how they behave in the situations studied is entirely a product of those situations, rather than of who they are and what they do outside of those situations simply because we do not have observational data about the rest of their lives (Hammersley, 2006).

However, in the realities of academic life, it is impossible to spend several years on research field, this may be the pressures of funding bodies for quick completion or the increasing pressure on academics for productivity or the short completion time of academic course (Reeves et al., 2013). In this situation usually, more academic researcher handle this issue by conducting focused ethnographies (Reeves et al., 2013). However, it is essential to keep in mind the issues that can happen while changing from traditional anthropology model to focused ethnography.

For effective time utilisation focused ethnographer uses a specific research question, a researcher with the insider or background knowledge of the cultural group, and intensive methods of data collection and recording, such as video or audio-taping, which can produce huge amounts of data quite rapidly (Higginbottom, 2013).

In short, any researcher, who selects ethnographic method to investigate their research has to keep in mind that ethnographer needs an adequate amount of time to spend in the field.

### **3.5. Ethnographic methods used to collect the data**

Ethnographers usually use participant observation, interview, and field notes as the methods for data collection. In this study, all three methods were used to collect data at different stages.

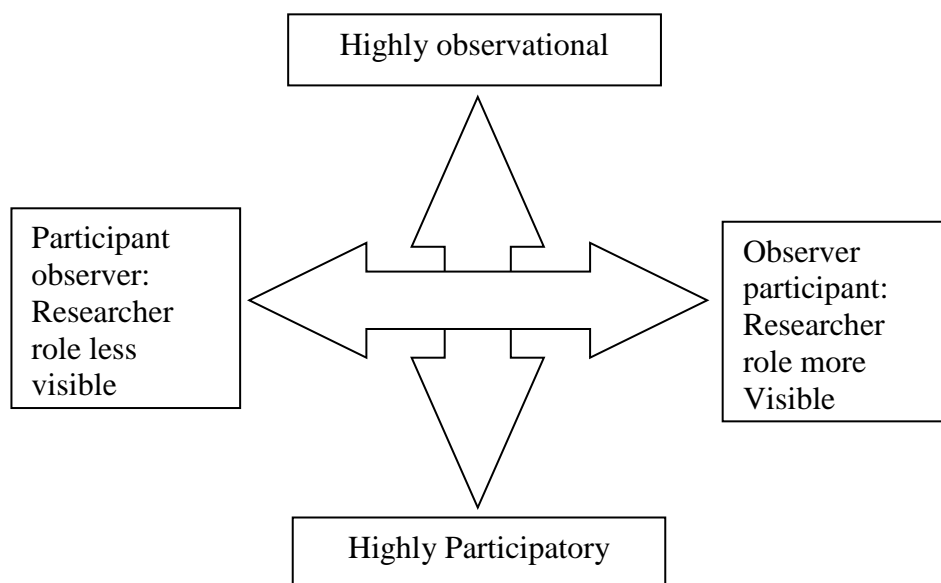
#### **3.5.1. Observation**

Participant observation is traditionally associated with ethnographic research and considered as the foundation method for ethnographic research (Whitehead, 2005). Usually, ethnographic researchers use the data that has been collected through the participant observation to build up the design for other methods, especially interviews (Reeves, Kuper, & Hodges 2008).

There are two types of participant observations, overt and covert (Li, 2008). In covert research, the identity of the researcher and the purpose of the research are obscured from the subjects being studied. Subsequently one cannot refer to the subjects of covert research as participants, seeing that they are not participating, merely reacting or being observed in their "natural environment" depending on the type of research being undertaken (Li, 2008). Such kind of research is considered more likely to provide detailed portraits of contextualised social realities. However, this method is controversial in terms of research ethics, mainly regarding the deception and lack of informed consent of the subjects being studied. Because of this serious controversy, covert observations remains as the least used approach in qualitative research methods (Li, 2008). However, covert research is rarely used to study certain remote and closed spheres of life, such as, criminal and deviant ones that simply cannot be investigated in an overt manner (Miller, 1995).

In contrast, in overt observations, the researcher reveals the intention of the research to the participants. The overt ethnographic approach allows the researcher to be honest with the participant because this overt approach is not facing the serious ethical criticism associate with deception or lack of informed consent. For this research a completely overt ethnographic approach was selected. Participant observation was selected as the primary data collection tool in the first stage of this study because it helps to gain a sense of what exactly happens in that particular context regarding the topic of interest.

In ethnography, it is important to get inside the participant's setting and observe the setting as closely as possible to collect the data (Crotty, 1988). But, the roles of the ethnographer vary according to the nature of the study or the theoretical approach of the study (Angrosino, 2007). There are four levels of participant observation that vary from complete participation to complete observation (Tedlock, 2007). The four levels of participant observation (Figure 3:3) include participant, participant-as-observer, observer-as-participant and observer only (Gerrish & Lacey, 2006).



**Figure: 3:3** Different types of participant observation (Adopted from Gerrish & Lacey, 2006).

Some researchers argue that a complete observer role can have some limitations and restricts the researcher from obtaining the more in-depth data (Agrosino, 2007). In contrast, Hammersley and Atkinson (2007) mentioned that too close rapport with the study subjects or the participants being observed may lose the objectivity to some extent. Regardless of different kind of observable roles, it can be very enlightening and useful if done appropriately (Roper & Shapira, 2000). In this study, the primary researcher adopted a role of an observer-as-participant. Moreover, it was felt that this type of observation enables the researcher to collect more information by immersing themselves in the study setting more fully than as a passive observer.

### **3.5.2. Field notes**

Field notes are one of the most fundamental and well-known data collection tools used in ethnographic studies (Speziale & Carpenter, 2011). Documentation of the observed data during participant observation consists of field notes (Hammersely & Atkinson, 2007). Field notes are recorded in a field notebook (Speziale & Carpenter, 2011). Field note consist of everything that is actually observed by the researcher including participant's behaviour, conversation, coming to and going from the setting, physical gestures and responses (Speziale & Carpenter, 2011). In addition to the objective observation field notes consist of the subjective responses to what the researcher observed (Hammersely & Atkinson, 2007). Daily field notes help to improve the interpretive and iterative process of ethnography through the repeated collection and recording of the data (Hammersely & Atkinson, 2007). Taking field notes also facilitates the ethnographic aspect of reflexivity (Speziale & Carpenter, 2011). In field notes, the ethnographer not only records his or her observations of the ethnographic setting,

but also his or her reactions to what is observed or experienced (Hammersely & Atkinson, 2007).

In this study, the researcher reaction on observed patient-therapist interaction as well as researcher's experiences with the settings and participants while spending the time in the institutional settings were included in the field notes.

### **3.5.3. Interview**

The Interview is considered as the most common tool for collecting qualitative data (Gerrish & Lacey, 2006). Interviews provide an opportunity to the ethnographer to clarify the doubts and know more about what the ethnographer sees and experiences during observation (Emerson, Fretz & Shaw, 2011). Mason (2002) identified three types of interviews as structured, semi-structured and unstructured interviews (Lace & Luff, 2009). All these types of interviews are based on the interpersonal exchange of dialogues, relatively informal in style and being narrative or topic centred or thematic (Mason, 2002). Both semi-structured and unstructured interviews were used to collect data from both patient and therapist in various stages of this study, in which unstructured or informal interviews were used in the initial stage to collect information or clarify doubts related to observed patient-therapist interactions. Semi-structured interviews were formed on the basis of all information collected in the first stage and it was used as the tool for collecting data in the second stage.

Unstructured interviews as interviews in which neither the question nor the answer categories are predetermined. Instead, they rely on the social interaction between the researcher and the informant or it is more like an informal conversation (Mason, 2002). Patton (2002) described unstructured interviews as

a natural extension of participant observation because they so often occur as part of ongoing participant observation fieldwork. This kind of informal conversational interviews was often included in the field notes.

Unlike un-structured interviews semi-structured provides some structure to the interview that helps to include topics, themes, or areas to be covered on the basis of the overall data collected in the first stage (Mason, 2002). Also, at the same time this facilitates rapport or empathy and permits a greater flexibility of data coverage (Smith & Osborn, 2008). In in-depth interviews, the interviewer commonly uses a few questions to facilitate the interview for obtaining further clarification or explanations about the topic of interest (Lace & Luff, 2009). Usually, a topic guide is used in the semi-structured interview and it allows the researcher to manage the interview (Lace & Luff, 2009). In addition to that, it reminds the researcher about the interview schedule while allowing the researcher to add more questions based on the questions raised during the interview regarding new topics introduced by the participant (Gerrish & Lacey, 2006). However, the interview may become more structured as the study progresses, as the researcher builds upon and clarifies ideas that have arisen from previous interviews and observations in the field (Gerrish & Lacey, 2006).

In this study two interview guides were prepared to conduct the semi-structured interview in the second phase of data collection. That is one for the patient (Appendix12) and one for the therapist (Appendix13). These interview guides are created on the basis of the findings obtained from the initial stage of data analysis (Gerrish & Lacey, 2006).

### **3:6 Data analysis: the approaches that used to analyse the data**

Different elements from different approaches were used to analyse the data of this study. The elements of Fairclough's three layered Critical Discourse Analysis is used as the the main analytical method of this study. The elements of pragmatics also used to analyse the data. The next section will discuss these analytical approaches.

#### **3.6.1. Fairclough's Critical Discourse Analysis (CDA) and the justification while it combine with the ethnography.**

Ethnographers usually face challenges to arrange the huge amount of data gathered from the research site during fieldwork. Consequently, the ethnographers themselves are responsible for selecting suitable approaches to arrange, document, analyse, and make sense of all the data.

In this research the discourse analysis is used into an ethnographic work. Throughout the 1980s ethnographers in United Kingdom brought combined ethnographic observations and discourse analysis into their research (Heritage & Maynard, 2006 ). In recent years many ethnographers include discourse analysis as a part of their investigation in institutional studies (Heritage & Maynard, 2006). This kind of investigation argues that the analyses of patient-therapist interaction are like an iceberg that is the subjectivity resides mainly below the surface of talk (Heritage & Maynard, 2011).

The main advantage of combining ethnography and discourse analysis is that both the approaches complement each other (De Melo, 2012). For example, ethnographic tools used to collect the data provided opportunity to observe in the natural socio-cultural context for a period of time (Hammersley, 2006). This could help to contribute in-depth knowledge beyond the text in terms of how people

behave and about the settings, the spatial and temporal situations, the participants and their social roles, and so on (Hammersley, 2006). Also, at the same time, for a proper understanding of discourse requires investigating the institutional contexts in which it is produced (Hammersley, 2006). The CDA framework explained by Fairclough (2001) is selected as an appropriate data analysing method of this study. Fairclough (2001) mentioned that textual analysis is best framed within ethnography. To assess the causal and ideological effects of texts, one would need to frame textual analysis within. For example, link the 'micro' analysis of texts produce in an institutional context to the 'macro' analysis of how power relations work across networks of practices and structures (Fairclough, 2001). In other words, the CDA researcher usually considers that the linguistic practice and social practice (non-linguistic) constitute one another and concentrate on analysing how societal power relations are established and reinforced through language use. This type of analysis seems to be most appropriate for the objectives of this research.

Social-cultural factors (age, social class, belief, gender etcetera), in one way or another influence peoples' interactions. Both psychologically and physiologically the therapeutic interaction happens in a particular socio-cultural context (Von Raffler-Engel, 1989). So, interactions between therapist and patients are affected by the socio-cultural context in which they occur. The dialectical nature of Fairclough's CDA framework not only concentrates on the spoken interaction between physiotherapist and patient but also helps to identify the socio-cultural contextual elements and its underlying power relation associated with the patient-therapist interaction (Faircalough, 2001).

During the analysis stage initially the key empirical findings of the research had been recognised through coding; a deductive way of analysis. Then in the



next stage was the process of abduction (using CDA) using theoretical concepts; in which empirical data are re-explained. The abductive reasoning is considered a form of logical inference or thought operation, which indicates that a specific phenomenon or event is interpreted from a set of general ideas or concepts (Danermark et al., 2002). Abductive reasoning promotes the level of theoretical engagement beyond providing the thick descriptions about what is observed at the empirical level. Unlike deductive reasoning, the abductive reasoning does not promise the definitive conclusions. The stages of Fairclough's CDA is explained in the next section.

#### **3.6.1.1. Stages of Fairclough's CDA**

Fairclough's CDA analyses the data through a three-dimensional framework. The three different layers of the analysis include the Descriptive analysis, in which the spoken or written text was analysed by considering the vocabulary and grammar of the text; the interpretive analysis, in which the relationship between text and interaction was analysed; and the Explanation, in which the relationship between the interaction and its wider social context is explored.

Descriptive analysis: The experiential, relational and expressive values of text including grammar vocabulary and textual structure are investigated in the stage of descriptive analysis (Faircalough, 2001). Through analysing the experiential values the CDA helps to illustrate how the text producer's experience the natural world or social world effect (Fairclough, 2001). The individuals' views of the world can be recognised by assessing the formal features with experiential value. The perceived social relationship between the producer of the text and its recipient is identified by the relational values (Fairclough, 2001). The expressive value

provides the idea about the producer's evaluation (in the widest sense) of the bit of the reality it relates to (Fairclough, 2001). This should expose the relevant parties in the text's social identities. Fairclough (2001) provided a list questions and a number of sub-questions, which help to identify the vocabulary, grammatical and textual features of the explained values when investigating the text. This is not intended as an all-inclusive list of questions, however it is a suggested list of possible directions or areas that could be investigated. Example of some of those questions (based on the above explained certain values) that used this study to analyse the textual features of the extracts are given in chapter 4, table 4:4

Interpretive analysis: The interpretation stage is the second phase of Fairclough's approach to CDA. Fairclough (2001) suggested that both the participants to an enquiry and the analyst are involved in ongoing interpretations of language in use, based on what is in the text or speech and what he calls member's resources (MR). MRs are the sum of the participants' and the analyst's background knowledge, including beliefs and assumptions about the context. According to this study, interpretive stage analyse the data specifically basised on the physiotherapy context. Fairclough (2001) suggested a set of questions for identifying discourse types in the situational context. Table 4:5 in chapter 4 explain about this.

Explanatory analysis: Explanation is the outer layer of the Fairclough's (2001) CDA and this layer is concerned with the relationship between interaction and wider social context. This stage is summarised by using questions based on ideology, social determinants and effects. Table 4:6 in chapter 4 explain about this.

### 3.6.2 Elements of pragmatism

It would be impossible to analyse any discourse without having a solid basic knowledge of pragmatic phenomena and the ways in which they work and interact (Alba-Juez & Mackenzie, 2016). Pragmatics provides discourse analysts with important tools and basic concepts.

There are two main schools of Pragmatics: the Anglo-American and the European Continental. The former can be identified with micro-pragmatics and the latter with macro-pragmatics. Micro-pragmatics is mainly concerned with specific theoretical discussions about topics such as assumptions (presuppositions, implicatures), speech acts and so forth. Macro-pragmatics places the emphasis more on the functional perspective (in a very broad sense) of language than on any theoretical point in particular (Alba-Juez & Mackenzie, 2016).

The discourse analysis, like pragmatics, is concerned with language in use and in context. According to Fairclough (2001) language is a social practice. He argued that 'language is an irreducible part of social life, dialectically interconnected with other elements of social life so that social analysis and research always has to take account of language' (Fairclough, 2003). According to this view, analysis should necessarily consider the form and function of text, how it is produced and consumed and how it relates to the social context where it is located (Richardson, 2006). In that sense, both the elements of macro as well as micro pragmatics have a connection with Fairclough's analysis of this study. This study used speech act and assumptions to analyse text. According to Fairclough, (2001) speech functions are related to the 'speech acts', which have been widely discussed in micro linguistic pragmatics. The conversational analysis

also considered as part of micro-pragmatism and the elements of this is used in this study to capture the textual features of the patient –therapist interaction. So, in that sense, it can be argued that the elements of micro- pragmatism have a connection with his study. Functionalists concentrate on the analysis of language in use, giving as much as, or even more importance to the context than to the text of utterances (Alba-Juez & Mackenzie, 2016). As mentioned before Fairclough provides equal importance to text and social context. Especially the interpretive and explanatory phases of Fairclough CDA helps to analyse the data in a wider socio-cultural aspect. In that aspect, this study uses the elements of macro-pragmatics in this study.

The next session will discuss the speech act theory and conversational analysis and its elements that used in this study to analyse the data.

#### **3.6.2.1 Role of speech act theory:**

Speech act theory is essentially an approach to language analysis. John Austin and John Searle developed speech act theory from the basic belief that language is used to perform actions and thus, its fundamental insights focus on how meaning and action are related to language (Moeschler, 2002). So the elements of Austin and Searle were used to support the analysis in the textual part of Fairclough's CDA in this study. Austin's speech acts theory, were divided into the locutionary act, illocutionary act and perlocutionary act. The locutionary act is the act of saying something with a certain sense or the act of uttering something meaningful and reference in the traditional sense. The illocutionary act is what an utterance does when uttered (Moeschler, 2002). That is the real actions which are performed by the utterance, for example, promising, commanding, offering and naming. The perlocutionary act is the act performed

by, or as a consequence of, saying something. That is speech acts that have an effect on the feelings, thoughts or actions of either the speaker or the listener. In other words, they seek to change minds such as persuading, convincing, scaring, enlightening, inspiring etcetera (Moeschler, 2002). For instance, if a receiver is warned by the utterance 'Do not come near the dog' then this (the fact of the receiver being warned) is the perlocutionary effect.

Searle (1969) categorised speech acts into five types: representatives, directives, commissives, expressives and declarations. Austin emphasized the conventional (direct) interpretation of speech acts in his theory. However, Searle (1969) not only explained about the conventional (direct) speech act, but also, describes the relevance of non-conventional (indirect) speech acts. According to Searle (1969) an indirect speech act is an utterance in which one speech act is performed indirectly by performing another. For example, understanding the motives behind utterances is often crucial to successful communication. But the relationship between the surface form of an utterance and its underlying purpose is not always straightforward. For instance, 'Can you pass the salt?'; is an interrogative sentence and so it expresses a question. Usually, the speaker's goal in asking a question is to get an answer (Asher & Lascarides, 2001). But, in this situation probably the speaker use this sentence with a different purpose (Asher & Lascarides, 2001). That is, it could be considered as a request, where the speaker's goal is for the interpreter to pass the salt. This is what Searle (1969) described as an indirect speech act, in which a requesting form of speech act is performed indirectly by performing an interrogative form of speech act.

This study uses elements of speech acts because it helps to acknowledge the crucial interplay between language and social context to arrive at an interpretation of utterances (Asher & Lascarides, 2001).

### **3.6.2.2 Role of Conversational analysis theory**

The conversational analysis theory comprises of different components include adjacency pairs, turn-taking, repairs, sequences, openings and closings, and feedback (Fitch & Sander, 2004). This study utilizes the elements of turn-taking to explain the textual features of Fairclough's CDA. Turn-taking is a type of organisational tool in conversation and discourse, it observes when and how people take turns in conversation (Fitch & Sander, 2004). Initially, the features of turn taking was registered informally by Goffman as early as 1955 (Schegloff, 2000). The work of Sacks, Schegloff and Jefferson (1974) offered the main explanation about turn-taking in the social sciences (Schegloff, 2000).

Turn-taking is concerned with the way in which participants in interaction hold turns, pass turns, get in and get out of a talk (Wu, 2013). Usually, there are certain linguistic or paralinguistic strategies that people adopt to take turns. These strategies include overlaps, pauses, eye-contact or body gestures (Wu, 2013). Sometimes, people who do not want to take turns, may be used backchannel responses, such as, mm, yeah, right, really, to indicate that they have no desire to take turns (Levinson & Torreira, 2015). Turn-taking may also vary in terms of socio-cultural factors.

### **3.7 Chapter summary**

This chapter explained the theoretical aspects of critical realist ethnography and its combination with CDA. It has also, discussed the role of speech act theory and elements of pragmatism that helped to investigate the research objective. The practical aspects of using these approaches are explained in this chapter; the collection and analysis of the data will explained in the next chapter.

# Chapter: 4 Research Methods

## 4.1. Chapter introduction

This chapter describes how the methods explored in chapter 3 were used to collect and analyse the data. Initially, this chapter considers about study design, study settings, ethical concerns, sample and the recruitment strategies used in both stages of data collection. It then describes how the data were collected in participant observation (stage 1) and semi structured interviews (stage 2), how the data were transcribed and translated for analysis, how the data was arranged and analysed using deductive and abductive analysis. The rigour of the study is also explained, and the researcher's reflections regarding gaining access to the research setting and participants.

## 4.2. Study design

This study was comprised of four steps include the first stage of data collection, initial analysis of the collected data (from the first stage of data collection), the second stage of data collection and analysis of the entire data collected in this study (Figure 4:1). The first step of this study was used participant observation to collect the data. Ten therapists and twenty patients have participated in this stage. During participant observation field notes, audio-recorded conversations and informal individual interviews were used as the tools to collect data. In, the second step, the collected data from first step is analysed with the support of the software Nvivo. The third step includes the second stage data collection by using semi-structured interviews. Second stage data was collected after eight months of first stage data collection. The information obtained from the initial analysis was used to form interview guide for collect the data in this step. Sixteen physiotherapists and sixteen patients were interviewed

at this step of the study. The last or the fourth step of this study were analysed the entire data collected from this study by using the elements of Fairclough's CDA and pragmatics.

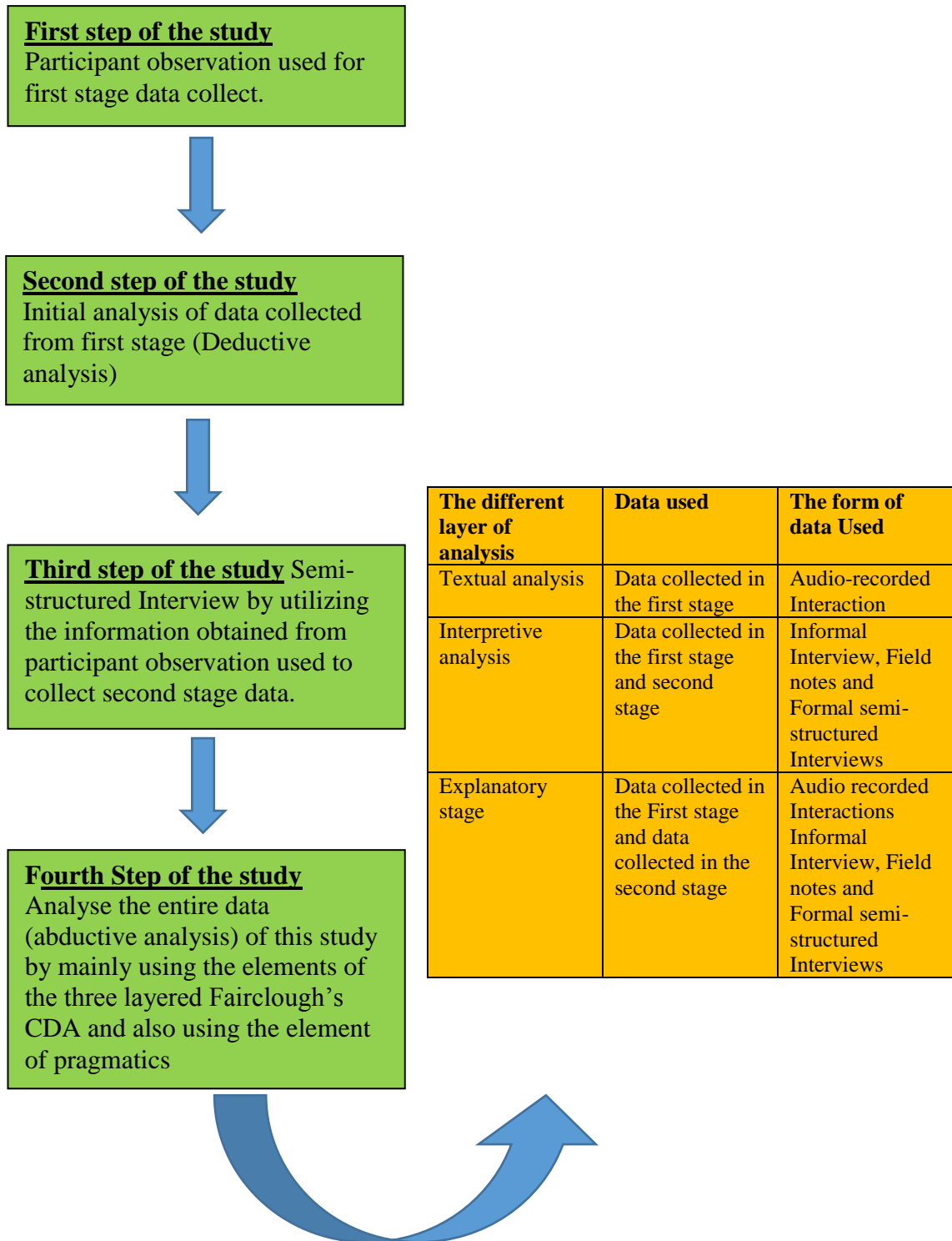


Figure: 4:1. The study design



### 4.3. Study settings

#### 4.3.1. Geographical location:

Both stages of data collection were carried out in three different physiotherapy outpatient settings in the south Indian state of Kerala (Figure 4:2). The researcher selected Kerala as a location for this ethnographic study because the researcher is from Kerala. Therefore, the researcher is familiar with the culture and language of Kerala. This enabled the researcher to conduct rich and more informed analysis.

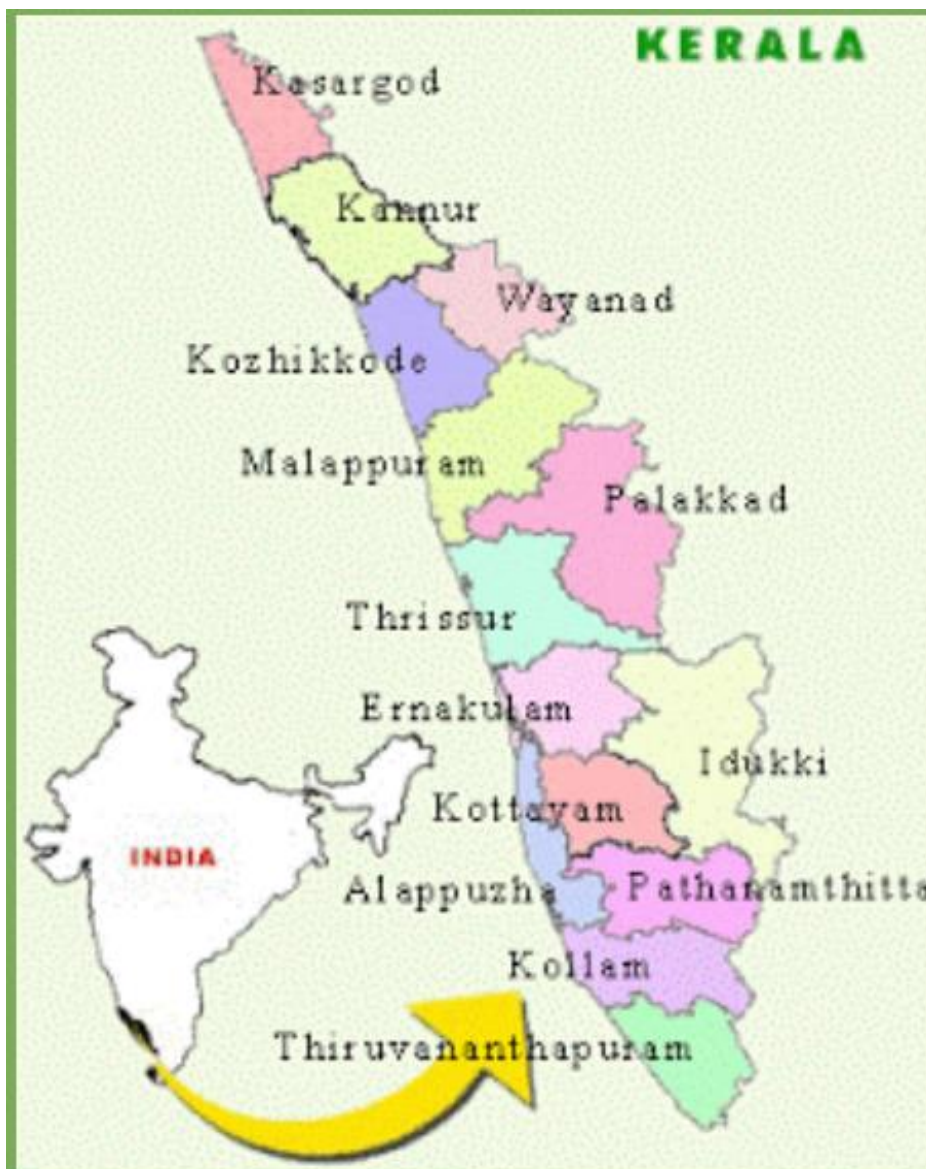


Figure 4:2: The geographical position of Kerala in Indian map and different districts of Kerala (Taken from Government of Kara tourism website)

Two private and one public sector health care organisations were conveniently and purposefully selected for collection data for this entire study. The selection of the two different sectors (public and private) provided an opportunity to observe the interaction between patients from the different social status of the society with the therapist working in different clinical contexts. The first stage data collection (participant observation), occurred in the private sector Medical Trust Hospital in Kochi and the public sector Medical College Hospital in Thiruvananthapuram. In the second stage data collection, participants were recruited for semi-structured interviews from the private sector Cosmopolitan Hospital in Thiruvananthapuram and from the Medical College Hospital used in the first stage. Sixty percent of the people accessing the public sector are from below the poverty level (BPL) (discussed in chapter 2). However, the majority of the population accessing the private sectors are from the middle class as well as from the high social class. All the three hospitals selected for this study were placed in the urban areas of Kerala.

The researcher was previously familiar with the settings of the Kochi Medical Trust Hospital because they had successfully completed their physiotherapy bachelor's course from the educational institution of the Medical Trust Hospital and had completed their internship in this hospital settings. The Medical College Hospital was involved in both data collection stages of the study, the familiarity gained from the first stage of data collection helped with the process of recruiting the participants in the second stage. The hospital settings will be briefly described in the following section.

**4:3:3 Medical Trust Hospital (MTH), Kochi (Ernakulam):** The MTH is a 750 bed multispecialty private hospital situated in Kochi since 1973. Kochi is one of the five largest cities in south India and its population density is 5900 per square kilometre (Cox, 2015). It is one of the most densely populated cities in south India. The MTH physiotherapy department, was set-up in 2005. Twelve physiotherapists were employed in the department for treating both inpatient and outpatients. The outpatient department is situated on the ground floor of the hospital. It has a waiting area, private cabins for treatment and an open area for exercise. Three physiotherapists are worked in the outpatient department including department head (male), one senior therapist (male) and one junior therapist (female); and two internship students (females). The other inpatient physiotherapists were also allocated to the outpatient department to help in busy situations. The majority of the patients who attended the physiotherapy outpatient department were referred by the specialised doctors (that is doctors specialized in orthopaedic, neurology excreta) from different departments of the same hospital. This outpatient department opened Monday to Saturday 9:00am to 6:00pm.

**4:3:2 Medical College Hospital (MCH), Thiruvananthapuram:** The MCH is a 2750 bed teaching public sector hospital situated in Thiruvananthapuram, the capital city of Kerala; it was founded in 1951. The population density of Thiruvananthapuram is 6800 per square kilometre. MCH is the oldest and most prestigious medical college in Kerala. The physiotherapy outpatient department is managed by the Department of Physical Medicine and Rehabilitation, established in 1968 as a pioneering institution for disability management and occupational diseases (Wikipedia, 2017b). Physiotherapy out-patient section is situated on the ground floor and includes a waiting area, private treatment cabins,

chief physiotherapist consultation cabin and an exercise area. The physiotherapy department employs five physiotherapists (four male physiotherapists and a female physiotherapist), a chief physiotherapist (male) one clerical staff (female) and one intern student (female). The majority of the patients who attend the outpatient physiotherapy section are referred by the psychiatrist at the MCH. The department's official opens were Monday to Saturday from 8:30 am to 2:30 pm

**4:3:4 Cosmopolitan Hospital, Thiruvananthapuram:** The Cosmopolitan Hospital is a 400 bed multispecialty private hospital situated at Thiruvananthapuram since 1982. This hospital has both inpatient and outpatient units. The outpatient physiotherapy unit is situated on the ground floor with a corridor as waiting area for the patients, a private cabin for treatment and an exercise area. Two senior male physiotherapists were handling the patients in the outpatient physiotherapy units in Cosmopolitan Hospital. The majority of the patients who attend the physiotherapy outpatient department were referred by the specialised doctors (doctors specialized in orthopaedic, neurology etcetera) from the same hospital. The opening time of this unit was from Monday to Saturday from 9am to 1:00pm.

#### **4:4 Ethical approval**

Ethical approval was gained from Sheffield Hallam University Ethics committee, (Appendix 1). Whilst the researcher was in the UK the authorities of MTH, MCH and Cosmopolitan Hospital were contacted with the aim of informing them about the interest of the researcher to conduct research in their hospitals. In addition to that email, a formal letter was sent to the private hospital authorities enquiring about the local ethics procedures for conducting the study in their institutions. The letter was attached to the information sheet about research,

supporting letter from the supervisor and the ethical approval letter received from Sheffield Hallam University. As per the positive response received through phone when the researcher went to India, they directly approached both of the private hospitals at different stages of data collection and received the approval to conduct the study (Appendix 2 and 5). In the public sector, the letters and the documents were directly handed over to the authority by the researcher and received the approval after the completion of the procedure from the government sector (Appendix 3 and 4).

The research complied with both the ethical processes sanctioned by the Sheffield Hallam University. The main intention of the ethnographer is to study subjects within their natural settings; so the researcher needed to study the participants within their natural settings. In such circumstances the researcher must be aware of certain ethical concerns; all those will mention in the next section of this study.

#### **4:4:1 Information sheets and consents**

##### **Information sheets and consent forms for first stage of data collection (participant observation)**

Before agreeing to take part in the research, all the volunteer participants provided (physiotherapists and patients) an information sheet that comprised of all the information about the research (Appendix 4 and 5). The information sheets described the reason for inviting them to participate in the study, the objectives of the research, the procedure for data collection, about the collected data and the anonymity regarding the participant identity. The participants were also informed about the voluntary nature of their involvement in this study; this provided them with the right to choose whether to participate or not. The

interested participants were given the consent forms. The researcher confirmed that the participants had read the information sheet carefully and understood what the study was about before the consent forms were signed. The signed consent form were obtained prior to the data collection occurring. Physiotherapist were given the English version of the information sheet (Appendix 6) and consent forms (Appendix 8). However, according to the need of the patient either the Malayalam (Appendix 9 and 10) or the English version of the information sheet and the consent forms were distributed (Appendix 7 and 8).

### **Information sheets and consent forms for stage one (Participant semi-structured interview)**

All the participants (both physiotherapist and patient) were provided the information sheets and consent forms and obtained the signed consent form from the participants as described earlier in the first stage of data collection.

#### **4:4:2 Data protection, privacy and anonymity**

All the audiotaped conversations obtained from either stage of data collection were recorded using a personal digital recorder. The recordings and the resultant transcripts were kept on a password protected personal computer, which is accessible only to the primary researcher. All the paper documents and the recorder were securely locked in a private drawer. The research findings did not disclose the actual name of the participants. Instead of actual names, codes were given in the transcripts. Participant's details are given in table 4:1 and 4:2. The signed consent form was the only location at which the pseudonym and the personal identity could be matched. All the participants were informed about their right to stop the observation at any time during the observation sessions and their right to stop the recording at any time during the interview or interaction.

#### **4:4:3 Risk assessment**

In stage one, the risk incurred by conducting the study was considered minimal. The data were mainly collected through participant observation of the patient-therapist interaction in the natural settings without altering the care or services system that people received (National Ethics Advisory Committee, 2012).

The participant interviews were considered unlikely to evoke sensitive issues that might lead to psychological harm. Therefore, it was also considered that there was a minimal emotional risk to participants in engaging with the research and no upset or distress was observed during the interviews. It was considered that there was a minimal physical risk to the participants except some participants travelling to provide the interview. However, on the basis of the mutual agreement, almost all interviews of the subjects were conducted inside the hospital after their treatment session or after their duty time. Interviews with the physiotherapist recruited through snowball sampling were conducted outside their working place in a mutually convenient and comfortable environment during daylight hours. A full travel risk assessment was undertaken prior to the visits to India to collect data and included strategies to minimise the risks while travelling with the data.

#### **4:5 Sample**

##### **4: 5:1 Sample selection**

Twenty-one physiotherapists and thirty six patients participated in this study. The participant demographics are presented in (table 4:1 and table 4:2 below). Patients were selected by using purposive sampling in both first and second stage of data collection. However, purposive and snowball sampling strategies

were used to select physiotherapists, who took part in this study (Gerrish & Lacey, 2006). Purposive sampling was used in first stage and snowball sampling was used in the second stage of the data collection for recruiting the physiotherapist; this was mainly because of the less number of physiotherapist working in the government sector. The participants were selected on the basis of certain eligibility (inclusion/ exclusion) criteria given below. Eligible participants were recruited directly on a face-to-face basis in both phases of this study.

### **Eligibility criteria for patient observation and interview**

- Patients receiving physiotherapy management from the government or private out-patient department (OPD)
- Willing to be involved in the study and able to provide informed consent
- Patients were able to speak Malayalam, Hindi or English and can read English or Malayalam
- Patients aged above 18 years old

### **Eligibility criteria for physiotherapist/student therapist observation**



- Physiotherapist currently practising in an outpatient setting in India and /or a student therapist currently receiving clinical experiences in private or government outpatient setting in India.
- Physiotherapist is managing outpatients in the patient department and/or student therapist in their period of internship after completing the bachelor's degree.
- Willing to be involved in the study and able to provide informed consent.
- Participants can speak Malayalam Hindi or English and can read English or Malayalam.





**Table 4:2: Details of patients participated in this study.**

Patient	Gender	Age	sector	Job	Therapist involved in interaction	Form of data collected
P1	M	70s	Private	Retired	PTB3	OB
P2	M	60s	Private	Retired	PTR5	OB
P3	M	30s	Private	Driver	PTO4	OB
P4	F	20s	Private	Student	PTB2	OB
P5	F	20s	Private	Student	PTO4	OB
P6	F	20s	Private	Student	PTO4	OB
P7	M	40s	Private	Business	PTO4	OB
P8	F	50s	Private	House wife	PTJ1	OB
P9	F	50s	Private	Retired Clerk	PTJ1	OB& I.I
P10	F	60s	Private	Nursery care taker	PTJ1	OB
P11	F	50s	Public	Retired Nurse	PTS10	OB
P12	F	30s	Public	House wife	PTM9	OB
P13	F	40s	Public	House wife	PTM9	OB
P14	M	40s	Public	Astrologer	PTS10	OB
P15	M	30s	Public	Politician	PTU8	OB
P16	M	60s	Public	Retired Military service man	PTM9	OB
P17	M	30s	Public	Building worker	PTR6	OB
P18	M	40s	Public	Artist	PTS10	OB
P19	M	30s	Public	Building worker	PTR7	OB
P20	M	60s	Public	Floor worker	PTR7	OB & I. I
P21	F	70s	Public	Retired School teacher	NA	S.I
P22	F	30s	Public	Teaching in College	NA	S.I
P23	M	30s	Public	Bank Employ	NA	S.I
P24	F	30s	Public	Engineer	NA	S.I
P25	F	40s	Public	Work at Restaurant	NA	S.I
P26	M	60s	Public	Security	NA	S.I
P27	F	20s	Public	Nursing Trainee	NA	S.I
P28	M	60s	Public	Security	NA	S.I
P29	M	60s	Private	Business	NA	S.I
P30	M	60s	Private	Retired School head teacher	NA	S.I
P31	F	40s	Private	Business	NA	S.I
P32	F	60s	Private	Domestic work	NA	S.I
P33	M	60s	Private	Retired government servant	NA	S.I
P34	F	60s	Private	House wife	NA	S.I
P35	M	50s	Private	Government servant	NA	S.I
P36	F	40s	Private	House wife	NA	S.I

S.I= Semi-structured Interview; OB=Observation; I.I=Informal Interview; Female=F; Male=M. NA= Not Applicable.



  Indicates patient participated in the **first stage** of data collection



  Indicates patient participated in the **second stage** of data collection



**Table 4:1: Details of therapists participated in this study.**

Therapists	Experience	Qualification	Age	Gender	Job title	Working sector	Data collection method
PTJ1	30 years	DPT	50s	M	Head Of the department	P.S1	OB & I.I
PTB2	2 years	BPT	20s	F	Junior Physiotherapist	P.S1	OB & I.I
PTB3	10years	BPT	30s	M	Senior physiotherapist	P.S1	OB & I.I
PTO4	5 months experience d Intern	BPT	20s	F	Intern physiotherapist	P.S1	OB & I.I
PTR5	5 months experience d Intern	BPT	20s	F	Intern physiotherapist	P.S1	OB & I.I
PTR6	30 years' experience	DPT	50s	M	Chief Physiotherapist	P.S2	OB & I.I
PTR7	12 years	MPT	30s	M	Scientific assistant(Physiotherapy)	P.S2	OB, I.I & S.I
PTU8	15 years	BPT	30s	M	Scientific assistant(Physiotherapy)	P.S2	OB, I.I & S.I
PTM9	15 years	BPT	30s	F	Scientific assistant(Physiotherapy)	P.S2	OB, I.I & S.I
PTS10	15 years	BPT	30s	M	Scientific assistant(Physiotherapy)	P.S2	OB, I.I & S.I
PTA10	3 and ½ years	BPT	20s	F	Head of the department	P.S1	S.I
PTR11	3 years	MPT	20s	M	Junior Physiotherapist	P.S1	S.I
PTV12	3 years	MPT	20s	M	Junior Physiotherapist	P.S1	S.I
PTA13	10 years	BPT	40s	M	Head of the department	P.S1	S.I
PTS14	17 years	MPT	40s	M	Senior Physiotherapist	P.S1	S.I
PTI15	15 years	MPT	40s	M	Senior Physiotherapist	P.S1	S.I
PTC16	20 years	BPT	40s	F	Head of the department	P.S1	S.I
PTR17	7 years	BPT	20s	F	Head of the department	P.S1	S.I
PTP18	20 years	BPT	40s	F	Scientific assistant(Physiotherapy)	P.S2	S.I
PTB19	15 years experience	BPT	30s	M	Scientific assistant(Physiotherapy)	P.S2	S.I
PTA20	20 years' experience	BPT	40s	M	Scientific assistant(Physiotherapy)	P.S2	S.I
PTD21	1year	MPT	20s	F	Trainee Physiotherapist	P.S2	S.I

P.S1= Private Sector; P.S2= Public sector; S.I= Semi-structured Interview; OB=Observation; I.I=Informal Interview; BPT= Bachelor of Physiotherapy; MPT= Masters of Physiotherapy; DPT=Diploma in physiotherapy; Female=F; Male=M

  This Colour code Indicate the physiotherapists who participated only in the first stage of data collection

  This Colour code Indicate the physiotherapists who participated both in first & second stage of data collection

  This Colour code Indicate the physiotherapists who participated only in the second stage of data collection

#### **4: 5: 2 Recruitment of physiotherapist or student therapist recruitment for participant observation and semi-structured interview**

Recruitments through institution were conducted on a face-to-face basis. The department head or chief physiotherapist provided an introduction to all the physiotherapy staff about the research during their break time. The main intention of this introduction was to brief the physiotherapy staff about the research and to seek help from them to recruit patients for this study. All the therapists or student therapists were given an envelope containing an information sheet by the department head. Interested participants were instructed to contact the researcher through the phone or inform directly (face to face). These people were then provided with the consent form, which they returned signed just before the data collection. Physiotherapist involved in more than one observation session were asked for their verbal consent prior to each observation session.

The physiotherapists recruited through snowball sampling were contacted by telephone and an appointment obtained with those who were interested. The snowball sampling is used only for physiotherapist who took part in the second stage of data collection. During the meeting the study was explained and the information sheet was handed over for them to consider further after the meeting. Then they informed to contact the researcher by phone if they were interested in taking part in the study. Once they informed their interest, mutually decided a comfortable and convenient place and time by phone. Then during the time of the interview provided the consent form to the participant and obtained the signed consent back from them just before the data collection start.

### **4:5:3 Patient recruitment for participant observation and semistructured Interview**

Patients were recruited face to face with the help of physiotherapy staffs from outpatient settings. Eligible patients who came to the outpatient physiotherapy department were provided with an envelope which comprises information sheet. They were asked to read these documents while they were waiting for consultation in the waiting area. Interested participants were instructed to inform the therapist directly (face to face) or through phone. Once the participants informed about their interest, then provided the consent form and obtained the signed consent just before the data collection.

During the time of providing the consent form for the patients, who recruited for interview were asked to give a convenient date and time to participate in the interview in the hospital area. The signed consent forms from the interview participants were obtained during the time of data collection.

### **4:6 Data collection**

#### **4:6:1 Stage 1: Data collection using participant observation:**

In stage one, the data was collected in the form of audio recorded interactions, field notes observations and from informal interviews with patient and therapist. Informal interviews were conducted more like a casual conversation in this study to collect the contextual as well as the observation related information. Eight weeks of observation were carried out in the outpatient physiotherapy settings from two different clinical settings from the state of Kerala. Participant observation was conducted at various times of the day, six days in a week from morning 9:00 am to evening 5:00 pm at the Medical trust hospital and from morning 9:30 am to 2: 00 pm at the Medical college hospital. A maximum of

two to three hours stayed at the observation site at a time. The patient-therapist interactions were audio-taped during the consultation or treatment sessions. In addition to the audiotaped conversations, concise field notes were written during observation. Therapists were individually and informally carried out interviews of therapist to clarify the doubts originated during the time of observation. Patients were also selected to clarify the doubts originated during the time of observation. Some of the interesting pieces of information that originated during those informal interview were audio recorded with their permission. All those information (bits of transcription of informal interview and field notes) included in separate files named 'informal interviews' in Nvivo (see section 4:8:2). The overview of the 1<sup>st</sup> stage data collection chart (Figure 4:3) given below.

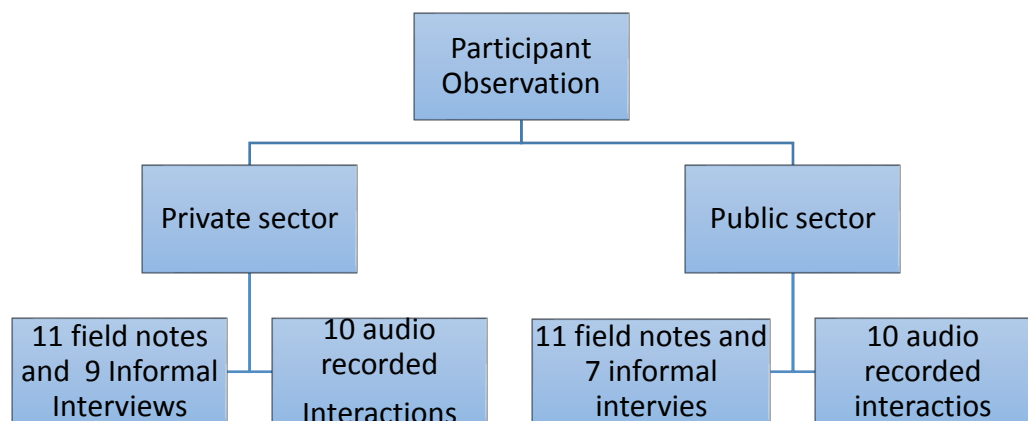


Figure 4:3 Data obtained from first stage data collection

20 audio recorded observations of the interaction between patient and therapist: 10 from the private sector and 10 from public sector were collected, coded and analysed by using thematic analysis. The field notes of audio recorded interaction and about the settings were taken: 11 from the private sector and 11 from public sector. Information obtained from informal interview also created as

separate file. So, seven informal interview obtained from public sector and 9 informal interview obtained from private sector.

#### 4:6:2 Stage 2; Data collection using semi-structured interviews:

Eight months after the first stage of data collection occurred, the second stage data collection was conducted using semi-structured interviews. The topic guide for this interview were created on the basis of the ideas that obtained from the first stage of data collection. Interviews were conducted on the face-to-face basis, they were recorded using the digital voice recorder and significant bits (further details on section 4.8.2) of the semistructured interview were transcribed (further details on section 4.8.1) by the researcher for detailed analysis. The researcher's reflections and comments regarding the interview were noted immediately after the interview. An overview of the total number of interviews given in the chart below (Figure 4:4).

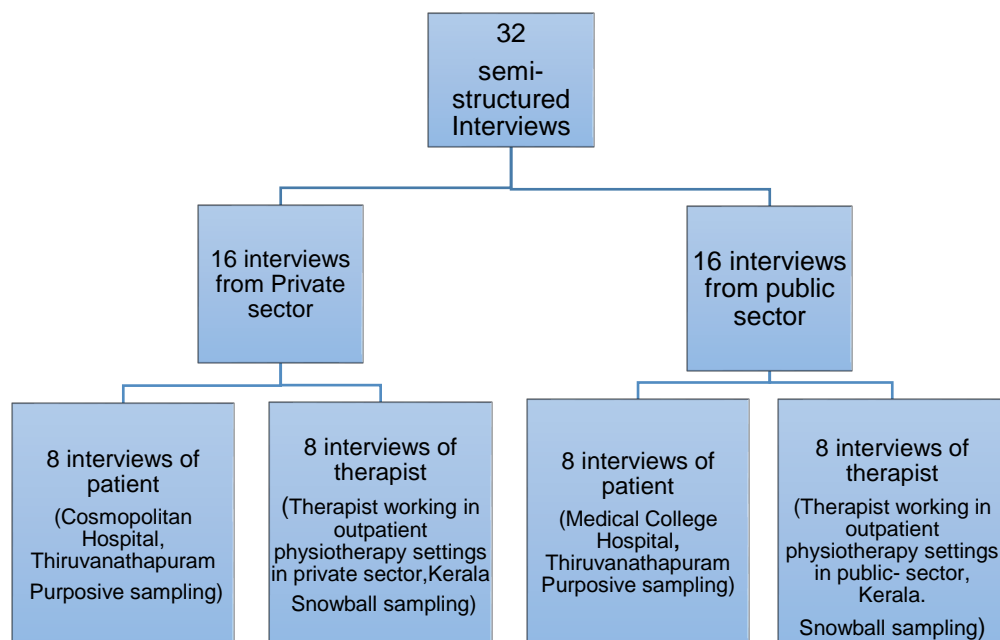


Figure 4:4 Data obtained from second stage data collection

## **Interview with the physiotherapists**

A total of 16 interviews with physiotherapists were undertaken; eight from the public sector and the eight from the private sector (interview guide in Appendix 13). In those seven physiotherapists provided the interview for this study were working in the same institutions from where the patients recruited for the interviews. Those physiotherapist's interviews were conducted inside the institution after the clinic working time. The remaining nine interviewees were recruited through snowball sampling and were conducted in a mutually comfortable, convenient time and places in daylight outside their working institutions. Two interviews were conducted in English, the other 14 physiotherapist interviews were conducted in Malayalam.

### **Interviews with the patient:**

Sixteen patient's interviews were taken from both private and public sector (eight each) (interview guide in Appendix 12). Those patients' interviews were conducted inside the institution immediately after the treatment session. All the interviews of the patients were conducted in Malayalam.

## **4:7 Reflections**

### **4:7:1 Reflection on gaining access**

The cultural insider identity of the researcher helped to ease the process of gaining the approval from all of the research settings. In the case of MTH, the researcher had a previous connection with MTH and its educational institution. This previous connection provided an added advantage to access the research setting easily. The field notes about the interaction between the managing director of MTH and the researcher illustrates this.

*“I briefly explained him about the matter of coming and provide the research information sheet and the university's ethical approval letter. He had looked at it and gave all to the admin staff. He didn't even read or looked at all the pages of that documents. He immediately asked me that was you a previous student at this institution? I said yes. Then he asked me about the details of my period of study in Medical trust institutes and its details rather than asking about the study”.*

In the MCH, the approval procedure was a bit more formal. The research went through different gatekeepers to get the government order to conduct the research inside the hospital. Before approving it, the physiatrist head conducted a 30 minutes discussion with the researcher about the research:

*‘When I introduced myself to the HOD, she pointed out the chair to sit down. Then she took all my research documents that I give to her and started to ask many questions related to my research what is the actual research about? What are you going to do in the physiotherapy department? How you schedule the data collection? What are the tools that used to collect data? I explained everything in detailed. Then She asked the details about myself Where are you from? How long have you been there in the UK? Where did you complete your study?’, Then she explained to me a set of general criteria’s (dos and do nots) of the institution while an outside researcher was collecting data from the hospital’.*

However, at the start of the second stage of data collection the procedure had changed. A formal ethics committee was formed there in medical college. A bit of the conversation with the vice principal from the field note quoted below.

*‘Then she said that there might not be difficult to get permission because this stage is the continuation of the previous stages of the same study. The vice principal reminds me by mentioning to write this stage data collection is the continuation of the first stage data collection that I conducted last year at MCH’.*

The researcher received the permission from the MCH ethical committee after two weeks from the submission of the application. In the cosmopolitan hospital, the researcher underwent a 15 minutes face to face discussion with senior administrative staff regarding the research and based on the documents



previously emailed to the hospital. During the discussion, as the senior administrator had known the researcher before he asked more about the research related question:

*'How do you collect the data? How long (the date) you need to stay here for collecting data? Is there any circumstances to touch the patient? Do you have any experience in working in the hospital with physiotherapy? When he gets satisfied answers with me, then he told I would put this application in the hospital management committee and let me know the result next week. He also added that So far the documents are clear most probably they will agree and you can start the data collection from next week'.*

After one week got the formal approval letter to research Cosmopolitan Hospital.

#### **4:7:2 Reflection about the hospital settings**

As the researcher had been a student at MTH institution, so the MTH setting was relatively familiar to the researcher. Even after nearly 5 years all most all daily professional activities and their roles, responsibilities, and facilities available to them remained the same especially in the department of physiotherapy. Not only the context but also certain physiotherapists including the head of the department (HOD) worked at MTH was familiar. So in this situation chance of losing objectivity was higher in this context. The researcher constant reflection helped to tackle this issue. Concerns about losing objectivity were quoted below from the field notes.

*'I found some possibilities of losing objectivity while working at MTH, one such difficulty involved engaging in many unnecessary duties outside of my research work. As I am familiar with the settings and few of the physiotherapy staffs, I found myself to occupy with discussions that irrelevant to my research work example, the clinical case discussions. According to the nature of this research to become so actively involved with the participants is not an intention.*

*However, I utilised the opportunities to stay with the participants whether it was having tea, lunch or just an informal talk during their free time. Initially, presumed conducting research is a 'give and take' relationship - if they gained help from me they would be more likely to pay back in return. However, over time I learnt that it also could interfere with my research work. As a result, I became concerned about whether helping them would have any impact on the generated data'.*

The experience from MCH was a bit different from MTH. It took a few days to become familiar with the settings and to create a good relationship with the physiotherapists. The below extract illustrate about this.

*'All most all therapist in the MCH is more senior than me and the setting is completely unfamiliar to me than that of MTH setting. So in the initial three to four days, I planned to spend more time in MCH to familiarise with the settings and to make a relationship with the physiotherapy.'*

MCH was included at the second stage of data collection as well. So, the previous experience that obtained from the first stage of data collection helped the researcher to quickly adapt to the settings later in the second stage. In the Cosmopolitan hospital, to familiarise with the settings and to develop cordial relationships with the therapist the researcher spend a bit more time in the department than had been originally planned. This helped to create a good rapport with the therapists quickly; thereby obtained enough support from the therapist's side to recruit the patients for interviews.

### **Reflection on 'observer as participant' role in the clinical setting**

In this study, I had an insider role (see section1.2). This helped me to behave naturally in accordance with local manners. For instance, it was natural to the researcher in terms of showing respect while meeting with the people in different genders, age, and social status in the research setting. How to address the different people according to their age and religious belief is significant in Indian culture. So, even in the institutional settings the professionals usually

address the client by using informal words to show respect or to create rapport. The below field notes is a reflection on how a cultural insider role helped me to identify the cultural meaning of certain words.

*'It was familiar for me that physiotherapist and other health professionals in Indian hospital settings address the patients by using certain informal words in accordance with patient age and religious belief to illustrate respect or to create better rapport with them. So, during the time of observation and interpretation, the knowledge about this was really helpful for me to identify the power flow between patient and therapist interaction'.*

Furthermore, cultural insider can build up the rapport and trust with the participants more easily than an outsider and is one of the reasons to choose ethnography as a methodology in this study (Hammersely & Atkinson, 2007). The below quote taken from reflexive field notes is an example of how an insider role help to create a better rapport with the participants in the research settings.

*'I used my familiar cultural words to address the people in the research settings and many time I identified that it helped me to achieve participants trust and create a better rapport with them easily'.*

*'While interacting with the participants I noticed from the beginning itself that they used the phrases and words like "as you know in our culture" or "our native place", "we" 'and "us". The usages of these words or phrases could be an evidence of their rapid acceptance me as one of the individuals among them. I believe that the native identity of mine as a reason to achieve this more rapidly'.*

Despite this, there were some occasions when I was considered a cultural outsider. Since 2011 I have been onwards the researcher is a student resident in the UK. In that case, it is relevant to check how this outsider student role impact in this ethnographic study. Many of the physiotherapy participants including the

senior physiotherapist have doubt about the significance of the choosing therapeutic relationship as the research topic.

*'Why you select this topic? Is that much important? For a PhD, you can select some other conditions. There is lot of significant condition, why you don't do research in those conditions? You only got this simple topic'.*

This can be identified as the matter of Indian physiotherapist lack of knowledge about the non -medical factors and its significance in the clinical context. When I was in India I had a similar perception regarding the non-medical factors. However, my perception about non-medical factors changed during my studies in the UK and I understood not only the medical factors but also the non -medical factors have an influence on patient treatment outcome. So, the above situation is an example of my outside research student identity or in other words, my outsider identity enables me to pick up therapeutic relationship as the research topic. Also, the above quotes emphasise the need of doing this research in the context of India to acknowledge the Indian physiotherapist about the importance of non-medical factors.

The outsider role also has an influence on approaching different gatekeepers to gain ethical approval.

*'When I introduced myself as a student from a foreign university then the head of the department in Medical College Hospital questioned my intention. By quoting a recent incident that happened in their hospital she warned me t not to create an issue by criticising the quality of the care provided by the government hospital with respect to the hospitals in the developed country. She strictly instructed me to avoid any kind of photographic or video- recorded data collection'.*

*'In MTH HOD thoroughly asked my background and connection with India before he agreed to provide ethical approval'. However, in MCH, my previous student identity help me to gain ethical approval very easily.*

Overall, in this study I adopted the observer-as-participant role. In this type of role, the observer is not only present their role as a researcher, but is also actively involved with the participants to a greater extent than a passive observer role in the research setting (Hammersely & Atkinson, 2007). In this study, the active involvement was in the form of an informal chat with the participant, asking questions to clarify what I had observed in the setting and act as an active listener while the therapist shares their professional concerns and condition of the patients. However, the researcher was reflexive about this particular role to tackle the issues of losing objectivity. The role taken by the researcher in the setting was quoted below from the field note:

*'As I am familiar with the settings and a few of the physiotherapy staff, I found myself to occupy with discussions that irrelevant to my research work example, the clinical case discussions. According to the nature of this research to become so actively involved with the participants is not an intention. However, I utilised the opportunities to stay with the participants whether it was having tea, lunch or just an informal talk during their free time' and thereby took an observer as participant role in the setting. Initially, presumed conducting research is a 'give and take' relationship - if they gained help from me they would be more likely to pay back in return.'*

I believe the observer-as-participant role helped to overcome the possible issue associated with the outsider student identity of the researcher because this kind of role enables the researcher to become more engaged with the participants in the physiotherapy setting than as a passive observer. This, in turn, helped to

create better rapport with the participant and to collect in-depth data from the participants.

#### **4:8 Data analysis**

Due to the usage of various data collection techniques including field notes observation, audio recording, interview during fieldwork, the researcher had a huge amount of data that had been gathered from the research setting. Therefore, various stages were used to organise and analyse the data for this research as described below.

##### **4:8:1 Transcribed verbatim:**

Transcriptions are the partial reorientation of the verbal interaction (Liddicoat, 2007). Therefore, it is difficult to capture every feature of the verbal interaction. Certain specialized signs and codes used to capture the patient – therapist interaction while it transcribed.

...	Short pause
.....	Long pause
?	Question
PTB2, PTB3...	Physiotherapist
P1, P2, P3....	Patient
Capital letter	Louder voice
()	Used for certain word that was not used in Malayalam, but it is necessary (grammatically) for translate in English. Example: you

In this study, initially, the audio recorded interactions between patient and therapist were transcribed in Malayalam using Roman script, then the data were translated to Indian English. This way of translation helped the researcher to stay very close to what was spoken (and to stay very close to the meaning what was conveyed) between the patients and therapist during their interaction. Different authors use different types of transcription patterns to treat the non-English data; this sometimes makes methodological or practical difficulties in literature. One of the eleven patterns explained by Egbert, Yufu and Hirataka (2016) is used in this research (Table 4:3). In this method the transcription pattern presented as two blocks, one is original talk in Roman alphabet on top and the translation on the bottom. However, the significant bits of semi structured interviews and informal interviews were directly transcribed to English. As the research knows both Malayalam and English language, the interviews were translated by the researcher.

**Table 4: 3: Transcription Pattern**

<p><b>Block one</b> (Malayalam version using the Roman script)</p>	<p><i>PTB3: Appacha, namukku nadakam?</i>  <i>P1: Ella, Aniku nadakanda</i>  <i>PTB3: Athantha? Ethu Nallathallathinu parayunnathu</i>  <i>P1: Venda. aniku nadakanda</i>  <i>PTB3: Epo nadannilengil pinenadakan pattilla</i></p>
<p><b>Block two</b> (English version using Indian English)</p>	<p><i>PTB3: Appacha, can we start walking?</i>  <i>P1: No. I do not want to walk</i>  <i>PTB3: Why? This is saying for your goodness.</i>  <i>P1: No I do not want to walk</i>  <i>PTB3: If you do not walk now then you never able to walk after that.</i></p>

## **4:8:2 Data Coding**

### **Coding of the data collected in the first stage**

Nvivo version 11, a software package for qualitative analysis was used to support analysing the data that collected in the first stage. This software package was used to facilitate transcript coding. Appendix 11 includes some of the screen short of Nvivo analysis. The detailed analysis of interactional features and associated contextual factors were analysed manually using the elements three-layered Fairclough's CDA analysis.

Initially, four different folders were created to structure the project using Nvivo. That is, two folders were created for placing the different forms of data that were collected from the MTH and another two created for the data from the public sector. All the interactional transcripts, transcripts of informal interviews, field notes were imported into the relevant folders. Nvivo provided an easy way of coding the data by viewing transcripts and choosing words or sentences and dragging and dropping them into respective nodes (themes). Different phases were used to in the coding process of this study: initial and focused coding. Close coding was used in the phase of initial coding. In this coding, the fragments of data (segments or events or lines) break into their component parts and identify the elements associated with the interaction features, the institutional and societal level contextual factors influence patient and therapist relationship. During the initial coding as the researcher was reading through the transcripts, free nodes were created. So, a number of free nodes were formed. Then, conducted focus coding. At this stage the free nodes and their codes were re-read. From those free nodes, some of the nodes were merged and some of the nodes were deleted. The nodes that obtained during the focus coding stage were



again rearranged and created as the main themes, themes and subthemes of the initial data analysis. This process enables the researcher to develop the interview guide for the second stage of the research. The data collected from the second stages were used to support the findings obtained from the first stage.

### **Coding of the data collected in the second stage**

The data from the semi-structured interview were analysed in 3 steps.

- 1) Initially, the researcher became immersed in the second stage interview data by listening to the audio recordings repeatedly. Throughout this process, the researcher recognised key ideas and conversations that related to the themes and were identified in the first stage and created the note of them.
- 2) Then these relevant sections of the interviews recordings were transcribed.
- 3) Codes and themes were manually created by using these transcripts (Appendix 14 and 15).

### **4:8:3 Detailed analysis using CDA**

A number of extracts were selected on the basis of their relevance to the research aim from the data that had been coded (coded from the pool of original transcribed data) in the initial stage for conducting deeper analysis manually. These extracts were then analysed by using the three stages of CDA (description, interpretation and explanation), that explained in chapter 3. The table 4:4, 4:5 and 4:6 describes the sample questions that used in the different stage (descriptive, interpretive and explanatory stage of analysis) to analyse the selected extracts.

**Table 4:4 Sample questions used to analyse at the descriptive stage of CDA**

(Taken from Fairclough, 2001).

Features	Example question	Sample text	Explanation based on the sample
Vocabulary	<p><b>Example 1</b> Are there words which are ideologically contested? (Experiential value)</p> <p><b>Example :2</b> What ideologically significant meaning relations are there between words? (Experiential value)</p> <p><b>Example :3</b> Are there markedly formal or informal words? (Relational)</p>	<p><i>P1: Leave me, this is my karma-phalam. People can't do anything for my condition.</i></p> <p><i>PTB3: Doctor referred here for walking, this is the time for walking. This is good for you appacha. P1: Leave me, this is my karma-phalam. People can't do anything for my condition. God will give the life experience on the basis of each and every one karmam. Everyone know that one day.</i></p> <p><i>PTB3: This is good for you appacha.</i></p>	<p>Karma-pahalam is a word which is ideologically contested.</p> <p>Here, the word 'doctor' by the patient and 'god' by the doctor to indicate the higher power to convince the each other.</p> <p>Appacha, is an informal word used by the therapist in the institutional context. This particular word used to show respect to elders in the local culture.</p>
Grammatical	What modes are used? (Relational value)	<i>PTS10: OK, lay down, Want to assess</i>	Imperative clauses.

Textual structure	What interactional conventions are used? (Example: turn taking)	<i>PTO4: Which standard (you) are studying?</i> <i>P6: second year B.com</i> <i>PTO4: which college?</i> <i>P6: Theresa</i> <i>PTO4: where?</i> <i>P6: St Theresa.</i> <i>PTO4: Oh Theresa's</i> <i>P6: ah...</i> <i>PTO4: Is your college off today?</i> <i>P6: ah,our lectures go for a strike today</i> <i>P6: what is your name?</i> <i>PTO4: xxx</i>	The initial bit of conversation was control by the therapist. However, later on the
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PTO4, PTS10,PTB3: Therapists  
P6,P1: Patients

**Table 4:5 Sample questions used to analyse at the interpretive of CDA (Taken from Fairclough, 2001)**

Type of analysis	Sample question used for look at the analysis	Questions description
Interpretive analysis	What's going on? Who's involved? In what relation? What's the role of language in what relation?	These questions addressed based on the situation context and intertextuality context. In this study it is based on the physiotherapy context

**Table 4:6 Sample questions used to analyse at the explanatory stage of CDA (Taken from Fairclough, 2001).**

Analysis	Elements of analysis	
Explanatory	<b>Social determinants:</b> What power relationship at societal, institutional or the situational level helps to shape discourse?	<b>Ideologies:</b> elements what elements of MR are drawn upon have an ideology character?

#### 4:9 Rigour of the study

Qualitative research tends to use what might be regarded as 'substitute' validity and reliability criteria, including trustworthiness, credibility, transferability, dependability and confirmability to improve the rigour of the study (Lincoln & Guba, 1985). This research adopt certain methods to illustrate the credibility and trustworthiness of the study.

To provide rigour when preparing a research design, the researcher needs to carefully consider not only the methodology but also the philosophical intent of the study (Wilson & McCormac, 2006). Critical realism as a philosophical underpinning of this research enables the researcher to employ multiple approaches to support causal analysis with an intention to provide multiple possible explanations. In this situation, it is important to know whether the combined method or data are credible (Wynn & Williams, 2012). One way of addressing this question is to establish the credibility of the findings through the method of critical multiplicism (Shadish, 1994). This method refers to the fact that research objectives can usually be approached from several perspectives, and frequently 'no single way is known to be uniformly best' (Shadish 1994). Thus, the researcher adopt this method are used multiple perspectives to attain the research goals, to choose the research questions, methods and analyses, and to

interpret the results (Shadish 1994). This research adheres to the principle of critical multiplicity in terms of data collection and data analysis. This, in turn, helped to conduct the research in an interdisciplinary manner (here, in this study, used discourse to solve the problem from the field of physiotherapy) rather than using the traditional methods to obtain the objectives of the study. In terms of data collection, this study collected several forms of data (audio-recorded conversation, field notes and interview data) from the different sectors (private and public) by using various data collection methods (participant observation and semi-structured interview). In terms of analysis, this study used multiple perspective to interpret a single set of data and this were happening throughout the analytical discussion stages with the supervisory teams. Details about critical multiplicity and how this improves the credibility by using multiple strategic approaches were explained in section 4:9:1.

Trustworthiness were also used as method to achieve the rigor of this research, which explained in the section 4:9:2.

#### **4:9:1 Critical multiplicity**

Critical multiplicity has been called a method of 'elaborated triangulation' (Guba, 1990) According to critical realist, triangulation is part of, but not equal to, the critical multiples approach (Coward, 1990). Triangulation has been defined as the combination of two or more theories, data sources, methods or investigators in the study of a single phenomenon (Kimchi, Polivka & Stevenson, 1991). However, critical multiplicity goes further in that it encourages the exhaustive study of phenomena from as many different perspectives as possible.

This ethnographic study used different methods to collect the data from the field. Shadish (1994) mentioned that ethnographic data is useful in triangulating

data sources adhering to the principle of critical multiplicity. In this case of using multiple tools or methods, many authors stress the necessity to provide reasonable justification for using more than one method in the same study (Parahoo, 2014). Here in this study different methods were used to explore the different aims of the research. For instance audio recorded interactions, informal interviews and field notes (in the first stage) to understand the naturally existing therapeutic relationship in Indian outpatient physiotherapy settings and the semi-structured interviews were used to identify the perspectives of patient and physiotherapist about the therapeutic relationship. Moreover, the findings drawn from one method (Participant observations) is supported by the other method (semi structured interviews). The data obtained from the semi structured interview again used for the detailed analysis of the entire data. This not only helped to enhance the validity of the research, but also increase the researcher's understanding of the phenomena being studied. In this way achieved the methodological triangulation. The data were collected through two different stages (the second stage data collected after eight months from first stage data collection) from three different sites through purposive sampling as well as through snowball sampling. Data were collected from different sectors (private and public sectors) helped to include patient from different social status, included therapists with different types of experiences. These were support to obtain the data source triangulation in this research.

The members in the supervisory team were related to different disciplines (physiotherapy, humanities and English) and this helped to interpret the data from different aspects. For instance, the humanities background from one supervisor helped to interpret the patient- therapist relationship in its social aspect and the physiotherapists helped to consider the therapeutic relationship more in the

medical context. This kind of involvement helped to create a theory triangulations in this project. So this study achieved critical multiplicity through method, data and theory triangulations

**4:9: 2 Trustworthiness:** Various methods were used to increase trustworthiness in qualitative research, the following section will describe some of the methods that used in this study to increase trustworthiness.

**4:9:2:1 Reflexivity:** Reflexivity permits the researcher to reveal their socio-cultural position, which in turn help the readers to identify the way in which the researcher's place in the society might have interfered with the research process or not. The researcher was born and brought up in a middle class Hindu Visya family in a village in South India and has been resident in the UK since 2011. Discussing and involving the entire research process with a research group such as the group of peer researchers or with the supervisors is another important way to engage in reflexivity (Parahoo, 2014). Three supervisors from the UK, all of them from the western socio-cultural background, supervised this study and were regularly involved in the discussion of the data analysis. Their different cultural background helped and supported very much during the data analysis. One of the important advantages was their ability to raise issues and ask questions based on the outsiders perspective, which is considered as a significant part of the reflexivity process. It again helped to reveal unknown meanings that led to further description and reflection on the research that, without the doubt, enriched the findings of the study.

#### **4:9:2:2 Prolonged engagement**

Establishing the trustworthiness of an ethnographic research depends very much on the time spent in the field and the level the researcher can truly claim to

have immersed into the context. Through this emersion in the situation, the researchers become aware of the context of the research and they are gain insight into the settings. So in this situation, it is essential to describe the emic and etic perspective of the researcher that described by Gerrish & Lacey (2006). Emic perspective means the view of an insider, in which the researcher is to some extent familiar with the culture being studied (Gerrish & Lacey, 2006). The outsider view is considered as the etic perspective, where the researcher may not necessarily be a member of the culture being studied (Gerrish & Lacey, 2006)

According to these terms, as described above the researcher is from the culture being studied and is familiar or as a part of the study settings before. Also, the research is resident in the UK and have been studying as a full time student since 2011, so in this aspect the researcher also an outsider. Therefore, the researcher's representation of both emic and etic perspective enable the researcher to view the facts from a different aspect. This definitely helped the researcher to understand the phenomenon being studied and provide a better explanation by bringing a professional and personal understanding of the socio-cultural aspect of the therapeutic relationship in an Indian context.

#### **4:10 Chapter Summary**

This chapter has described the methods that were used to conduct this study. The chapter has explained about the selected geographical and institutional settings of this research, about sampling, recruitment process, different stages of data collection process, practical concerns of ethical issues, researcher's reflection on gaining access, researcher's reflection on study settings, step by step data organisation and analysis, use of Nvivo software and the approaches that used to obtain the rigorous of the result.



The next chapter will describe the findings that emerged through the three layer CDA analysis. This will provide the meaning of different domains of the therapeutic relationship in its textual, discourse and social aspects.

## Chapter 5: Introduction to the Findings

### 5:1 Chapter introduction

This chapter provides an introduction about the findings. Three main themes were identified and are presented in the three chapters in this thesis. These chapters will discuss how the discourse associated with each theme influence on the therapeutic relationship.

### 5:2 Introduction to the findings

Total fifteen audio-recorded conversations were analysed in detail to describe all these three themes and the semi structured interview documents from patient and therapist were also used to support the analysis of each audio recorded interactions. Each theme was analysed in its textual, discourse and social level using the sample extract and the supportive interview documents (Figure 5:1). The themes and subthemes are presented in the table below (table 5:1).

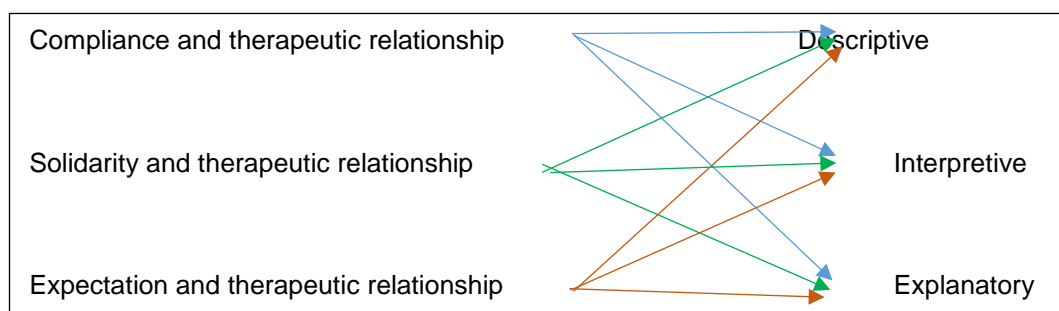


Figure 5: 1Themes based on Fairclough CDA

**Table 5:1 Themes and subthemes**

<b>Themes</b>	<b>Sub-themes</b>
<b>Patient's compliance and the therapeutic relationship</b>	Compliance Non-compliance
<b>Solidarity and the therapeutic relationship</b>	Shared narrative via medical discussion Shared narrative via non-medical talk
<b>Expectation and the therapeutic relationship</b>	Incongruence between patient and therapist

**Patient's compliance and therapeutic relationship:** How the contextual, linguistic and underlying power mechanisms related to patient's compliance affect in creating a therapeutic relationship. Under this theme there are two subthemes include compliance and non- compliance. The analysis of the subtheme compliance looked at how the patient compliance related conversations help to create a better therapeutic relationship and the strategies adopted by the therapist to support the patient's interest to compliance with the treatment. Found certain contextual factors that influenced patient compliance, this, in turn, influenced in creating the therapeutic relationship and the power flow between therapist and patient in compliance related conversation. The subtheme non- compliance looked at how the patient illustrated their resistance to compliance with the treatment, how the therapist handled such kind of resistance

and type of effort that therapist put to make the patient compliance. Possible contextual factors for patient non-compliance and how the possessed power of the patient and therapist interacted in this kind of situation.

**Solidarity and therapeutic relationship:** This theme looked at how the solidarity illustrating conversations between patient and therapist influenced in creating a better therapeutic relationship. This theme explains interactional features, different contextual factors and the involvement of power associated with solidarity conversations and how these elements influence to form the therapeutic relationship. Encourage the patient to share their narratives and show align with patient narratives was found as the common strategy that used by the therapist to illustrate solidarity to the patient. So, based on the content of these conversations two subthemes were identified: medical related shared narrative and non-medical related shared narrative. In medical related shared narratives, the therapist encouraged the patient to share their medical related topics during the interaction. In non-medical related shared narrative, the therapist encouraged the patient to share the non-medical topic during the interaction. These strategies could be identified as a way to create a better therapeutic relationship.

**Expectation and therapeutic relationship:** This theme illustrates the interactional features, the contextual factors and the involvement of power in patient expectation and how it associated with the therapeutic relationship. This theme comprised of a subtheme: incongruence between patient and therapist. The analysis of this subtheme incongruence between patient and therapist looked at how the patients expressed their concerns, demands and doubts when they had not received the expected outcome or expected treatment and in such situation how the therapist handle the patient. Also, looked at how the therapist

unawareness about the patient expectation led to the incongruence between therapist and patient. The subtheme was looked at the contextual as well as power involvement found in these kind of conversations and how these influence in creating a better therapeutic relationship.

**5:3 Chapter summary:** This chapter provided an introduction to the findings. The next three chapters will explore each of the theme and subthemes. Each chapter provides the justification about how the themes connect with therapeutic relationship. Each subtheme was interpreted and explained based on the conversations and from the interview data collected from patient and therapist. Literature also used to support the process of analysis. As this research is based on critical realist perspective, an abductive style of analysis can see throughout the chapters of findings. According to critical realist, it is difficult to find reality, but, certain knowledge may be nearer to the reality than other knowledge. So, based on patient-therapist conversations, patient and therapist perspective and the previous literature this study conducted an attempt to reach closure to the reality. However, this studies not provide definitive conclusions about the findings.

# **Chapter: 6 Patient compliance and Therapeutic relationship**

## **6:1 Chapter introduction**

This chapter describes how the discourses associated with patient compliance and non-compliance influence the therapeutic relationships and describes under two subthemes: non-compliance and compliance. According to the relevance of research objectives, six sample extracts (audio recorded patient-therapist interactions) were selected to explain these subthemes. The extracts consisted of patient's treatment compliance and non-compliance related interactions between patient and therapist during the time of treatment sessions. As mentioned in chapter three the textual features of patient-therapist interactions, the contextual factors associated with these interactions, the involvement of the power they possess and how these influenced therapeutic relationships are explained in this chapter. In order to understand the context of the discourse in a better way, the therapist and the patient perspectives that were obtained from their semi-interviews (conducted in the second stage) were used as the supportive resource to interpret the extracts. The end of this chapter provides a synthesis table comprised of the relevant results obtained from textual, interpretive and explanatory stages of analysis.

## **6:2 Patient's compliance and Therapeutic relationship**

There is a group of patients who do resistance to the treatment plans that are necessary to manage their conditions. The reason for their resistance varies: they do not think that their condition is severe enough to modify their behaviour or change their belief that obstructs to accept the treatment regimen, fear of symptoms, previous experiences, affordability, miscommunication between patient and therapist, lack of awareness, accessibility issues, too busy or stressed life, attitude. It becomes quite apparent that knowing what to do with patient's non-compliance and putting the knowledge into action to solve these issues are very challenging matters in a health professional's life. Much previous studies in the context of rehabilitation consistently found that better therapeutic relationship was associated with better treatment compliance (Hall, 2010; Vong et al., 2011; Ferreira et al., 2013; Babatunde, MacDermid, & MacIntyre, 2017). Greenhalgh and Heath (2010) revealed that good-quality therapeutic relationship improves patient satisfaction. The importance of patient satisfaction is emphasized by the evidence that satisfied patients are more likely to demonstrate compliance with the treatment strategies, attain more successful treatment outcomes and have a higher quality of life (Hush, 2011).

However, sometimes the resistance from patient's side to comply with the treatment or to the therapist's advice not allow the therapist to create a better therapeutic relationship. If there arose any obstruction to form a better therapeutic relationship, it negatively influences the therapist's ability to provide good arguments in support of the recommendations for the specified treatment or behaviour (Newman, 1994). One of such kind of situation explained by PTM9 is given below.

*'I had an experience about patients improper adhere to the exercise. She doesn't do the exercises at home she always said excuses like she needs to look*

*after her two grandchildren. Always is she came late to the given schedule I gave 40 minutes schedule but she came late. This irritated me a lot and I felt I am wasting my time for her'. (PTM9)*

Here, the PTM9 described how patients non-compliance affect negatively on her. This kind of negative emotions perceives PTM9 possibly reflect on her behaviour while interacting with the patients with similar behaviour. PTR7 and PTR11 also explained how the patient non-compliance affects them as a therapist and is given below.

*'Usually, low educated people with high financial status seems not completely adhere to the treatment program, if they got a bit relief they will not complete the entire treatment course because they do not like to spend more money....If the patient couldn't afford the treatment. Then we can understand ... But this...also they do not listen what we try to educate or they ignore the fact of doing complete treatment program. This is a bit annoyance for me. (We putting our maximum effort, but...they leave in the halfway ...' (PTR11).*

*'Every disease has an expected outcome, if the patient does not comply with the treatment, then we do not get that expected outcome. That definitely affect our satisfaction and... our interest becomes reduced toward that kind of case. This, in turn, affects the patient-therapist relationship' (PTR7).*

The above quotes were also illustrated how patient's non-compliance behaviour negatively affect the therapeutic relationship. There is another example given below, in which patient shared the experiences on how their non-compliance behaviour influence the therapist's response.

*'Sometimes I didn't get time to do the exercise at home. When the sir assess they know if we do the exercises regularly or not. If he recognised that I didn't do the exercise then sir questioned about the reason. Sometimes scold me. But, I know it's all for my healing' (P25).*

*'Sir, told me to buy and set a pulley in my house to do the exercise at home. Initially, I didn't follow his instruction. He asked me a couple of times about this and I answer I didn't set the pulley at my home. So he told me if you didn't buy the pulley then I will buy it for you. Then I said no (smile)...Actually, I was lazy.*

*He informed me that if I do not buy it next time. He definitely going to buy that for me ... Actually, he was bit unpleasant in that matter. After that, before my 4<sup>th</sup> appointment, I bought the pulleys and practised home exercise' (P31)*

So the above evidence illustrated that there was a possibility that patients non-comply behaviour or verbal resistance to comply with the treatment affect the therapeutic relationship. Previous literature from rehabilitation specifies the necessity of good quality relationship to make the patient comply with the treatment. However, none of the literature in rehabilitation identified how the socio-cultural factors influence patient's behavioural resistance or how the linguistic elements related to compliance or non-compliance affect in creating a positive therapeutic relationship. So the next section of this chapter will provide the detailed analysis of how patient's compliance related issues impact on therapeutic relationship.

### **6:2:1 Non-compliance**

Some patients adopted an unwillingness to comply with the treatment. Such, non-compliant patients used both direct and indirect interactional resistance in this particular context during their interactions, which identified to affect the therapeutic relationship. In this specific context, patients had expressed the belief and the behaviour of consumerism as the part of their indirect verbal resistance to the treatment program. The extracts one, two and three will explain the communication strategies used by the patients and the therapist regarding the non-compliance and how it influence on therapeutic relationship. Also, the power relationship that they possessed and the interpreted contextual factors influence on therapeutic relationship during the interaction of non-compliance.

#### **Extract: 1**



In the following extract, the young male therapist made different attempts to motivate and reassured the patient to do the weight bearing (the treatment). But the patient expressed his resistance throughout the conversation and he expressed his belief as the part of his verbal resistance to the treatment program. However, this study also interpreted patient's resistance could be the product of patient's and therapist's age related attitude or patient's pain related issues on the basis of the evidence that obtained from the participant's interview and from the literature. This interaction was taken from an out-patient physiotherapy department in the private sector. The interaction was between the male physiotherapist, a male old age patient above 70 years of old and two bystanders. The patient had been referred to the outpatient department for weight bearing after a few weeks immobilization following a leg fracture. The patient was on a stretcher; the therapist tried to move him into a wheelchair with the help of two trainee physiotherapist and tried to convince the patient to walk. The conversation in this extract was an attempt to provide physiotherapy treatment to an older patient.

***PTB3: Appacha, namukku nadakam?***

***P1: Ella, Aniku nadakanda***

***PTB3: Athentha? Ethu Nallathallathinanu parayunnathu***

***P1: Venda. aniku nadakanda***

***PTB3: Epo nadannilengil pinenadakan pattilla***

***Bystander (Wife): Avaru parayunnathu Kelku walker vechu nadakunnathengane anennu avaru padippichutharum.***

***P1: VENDA. ANIKU NADAKANDA ANE ONNU VERUTHE VIDU***

***PTB3: Doctor engottu ayachirikunnathu nadakananu, epo apachanu nadakanulla samayamay. Ethu Appachante nallathinu vendiya***

**P1: Ethu ante karmaphalamanu Arkum onnum chayyan kazhiyilladaivam orurutharkum avaravrude karmathinanusarichu ulla jivitham daivam tharum. Allavarum athu orudivasam manasilakum.**

**Bystander (Wife): Onnu nirthu ethu. Ethu nammudeveddalla. Avaru parayunnathu sredhikku**

**Bystander (Granddaughter): Avarodu co-operate cheyyu valyappacha.**

**PTB3: Appacha ...appo apozum ingane erikanano... nannumu just onnu ninnenkengilum nokkam**

**P1: Venda. Njanparanju vendannu... Ningal ane anthina engane anubhavippikunnathu. Njan paranjallo aniku nadakanda.**

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**PTB3: Appacha, can we start walking?**

**P1: No. I do not want to walk**

**PTB3: Why? This is saying for your goodness.**

**P1: No I do not want to walk**

**PTB3: If you do not walk now then you never able to walk after that.**

**Bystander (wife): Listen to them, they teach you how to walk using walker**

**(PTB3 ask for help for another physiotherapist to stand up the patient from the wheelchair; another one intern-physiotherapist immediately brings the wheelchair close to the patient and the therapist and another intern-therapist made him sitting position)**

**P1: NO, I DON, T WANT TO WALK.LEAVE ME**

**PTB3: Doctor referred here for walking, this is the time for walking. This is good for you appacha.**

**P1: Leave me, this is my karma-phalam. People can't do anything for my condition. God will give the life experience on the basis of each and every one karmam. Everyone knows that one day.**

**Bystander (Wife):Stop this, this is not our home, listen what they saying**

**Bystander (Granddaughter): Please co -operate with them valyappacha**

***PTB3: Appacha...so are you going to sit always like this... we can just try at least standing***

***P1: NO. I said no. why you make me suffer. I said I do not want to walk.***

As mentioned above here, the patient himself presents as a believer of karma-phalam and the expressed belief in karma-phalam forms part of his verbal resistance to the treatment program. The word Karma-phalam is an ideological belief of Indians. The meaning of Karma-phalam is 'fate or destiny from one's previous action'. Here, the patient used this word in its negative aspect (fate). This can be found in the line '*this is my karma-phalam*'. The karma-phalam basically encourages people to passively accept their problematic situation rather than taking an active role to solve the problem (Smiha, Noble & Chathurvedhi, 2013). In that sense, it seems to be an opposing ideology to the philosophy behind the physiotherapy, which encourages the patient to take the active role in their life (as discussed in chapter 1).

Otherwise, it can be considered as an attempt by the social agent to texture the text to make a justification for his resistance (Fairclough, 2003). According to Fairclough (2003) in a face-to-face conversation, the text is a transcript of what is said, and to a degree, one can see meaning-making going on by looking at how participants respond to each other's conversational turn. There might be some other hidden cause for the resistance to the treatment program, for instance, fear of pain. The therapist received the usage of karma-phalam as patient's resistance against the treatment program and this is apparent in the line starting from '*Appacha...so are you going to sit always like this*'. Both the

bystanders in this conversation also received the meaning of Kama-phalam as a way of resisting the treatment program, this can be seen in the patient's wife response *'stop this, this is not our home, listen what they saying'* as well as from granddaughter's response *'please co -operate with them valyappacha'*. That means both of the bystanders create an alignment with the therapist's stand in this conversation (Goffman, 1981).

As mentioned before pain could be an underlying reason for the P1's resistance to treatment. Two senior physiotherapists expressed their views about the patient's age and their level of pain tolerance and is given below.

*'Age is a factor in pain tolerance, older patients do not tolerate pain. As a result of this, they do not cooperate. That make some problem for us to give treatment' (PTA13).*

*'Most of the old age patients do not even allow to touch because their tolerance is very less.'* (PTP19)

According to PTA13 and PTP19 older patient's had less pain tolerance and this, in turn, led to patient's resistance to the treatment program. Many previous studies provided the equivalent and consistent evidence that decrease in pain tolerance was associated with increasing age (Tucker et al., 1989; Wadner et al., 2012). Van den Hout et al. (2001) found that the pain related fear resulted in lower pain tolerance in general. So, these evidence point out that pain related issues could be considered as a reason behind the P1's resistance.

In extract one therapist used an informal ('appacha') word to address the patient. This kind of informal address may be led to a situation to move away from the overt organizational hierarchy; Fairclough et al. (2003) mentioned this as a societal 'informalization' (Fairclough, 2001). However, according to Misztal (2000), one must immediately add an even informal usage in a conversation

shows inequalities which can be attributed to the social relations between participants; for instance, based on age or gender. Here, the patient was over 70 years old and the therapist was in his 30s. The word 'appacha' was an informal word used to show respect to elders in the local culture. So addressing the patient by using this informal word the therapist showed his respect to the older patient.

To identify the power relationship, the large age difference between the therapist and patient should be considered. As mentioned above in Indian culture older people are treated with great respect. Certain therapists, who took part in this study explained that patients within certain age groups are considered easy to handle. The similar opinion came from patient's side as well, see the example below.

*'Patients in our age are no problem, they behave friendly at the same time they give respect' (PTA10).*

*'Middle age people are very understandable'. (PTP19)*

*'Young age male patients are easy to handle. They understand things easily and they are very cooperative'. (PTR7)*

*'Before there was a Philip doctor he was nearly my age. We both like friends'. (P30)*

Here, PTR7 was a young male therapist, PTP19 was a middle-aged female therapist, PTA10 was a young aged female therapist and P30 was an old age patient. From these quotes it is clear that regardless of age group (middle, young or older) both patients and therapists were comfortable with their own age group of creating a better relationship; that may be influenced better treatment compliance. A possible balance of power that they experienced while interacting with the similar age group of patients/therapist might be the reason behind it. According to the contextual information in extract one, the patient possessed age-related power might be created a clash with the expert's (therapist's) power of

knowledge. Two young physiotherapists from the private sector explored their perspective about *the* old age patient's compliance quoted below:

*'Old age patients usually have a feeling that nothing going to happen at this age by doing these exercise' (PTA10)*

*'People after 65 or near to 70 will think there is no use to do exercise at this end stage' (PTR11)*

According to PTA10's and PTR11's perspective, the attitude of the old age patient had an impact on their treatment compliance. Literature from various context found that different kind of patient's attitude had a strong influence on patient's compliance to the treatment, which in turn affects the therapeutic relationship (Al-Eisa, 2010; Back et al., 2017). A Swedish study considered age as one of the factors that could influence the patient's attitude to exercise-based rehabilitation compliance (Back et al., 2017). Their study found that some patients felt that exercise was meaningful in order to maintain or increase physical fitness as they age, while others believed that they were too old to get any benefit from exercise (Back et al., 2017). But, a clinical audit conducted in the context of Saudi physiotherapy setting identified that old age patients with mechanical back pain were more comply with physiotherapy treatment than younger patients (Eisa, 2010).

Back et al. (2017) mentioned that old age could be described in relation to a restricted future, for which patients wanted to create their own meaning. So, in this aspect, what PTA10 and PTR11 said may be considered as an underlying cause of the act of P1 in extract one. That is the age-related attitude of P1 possibly influenced his behaviour in that particular context. The expressed resistance by P1 to the treatment program could be explained as a reflection of his behavioural attitude.

Here, PTA10 and PTR11 perspectives may be considered as the young physiotherapist perspective to handle the old age patients and these therapists might be expressed this opinion on the basis of their previous experience with old age patients. In this sense, in extract one, the PTB3's (here, young therapist's) behaviours towards the old patient could be considered as a reflection on his previous experience. As an expert, an effective kind of education from the side of physiotherapist could be helped to change age-related patient's attitude. For instance, in extract one, an additional effort from the therapist to educate the patient about the causes and effects of physiotherapy treatment for his condition considered as a better effort than used a warning '*If you do not walk now then you never able to walk after that*'. Otherwise, Identifying patients preferred treatment strategy and refer or provide according to that could be an effective approach to make the patient compliance with the treatment.

Another interesting fact identified that while arguing with each other both participants referred to a 'higher power' in their conversations to convince each other. The therapist referred doctor as the higher power ('*doctor referred here for walking..*') then the patient referred to the higher power of GOD ('*God will give...*'). However, from the conversation, it was clear that the attempt was not adequate to convince each other. Therapist also showed a criticism about the patient decision ('*Appacha...so are you going to sit always like this... we can just try at least standing*'). But the patient has continued his resistance.

This extract was taken from the context of private health care sector. So it is necessary to consider the power of patient and physiotherapist in private care settings. Patients attending private sector are likely to be the group with the greatest potential for adopting a consumerist relationship with health care professionals (Wiles & Higgins, 1996). Therefore, the private patients possessed

certain specific power because of their market position, to affect the patient–therapist relationship. Consumerist attitudes to health care suggest new power relations with patients having greater autonomy than the professional. So this type of consumerist power of the social agent (patient) might provide him with enough freedom to oppose the expert opinion.

## **Extract: 2**

This conversation was also an example of patient disagreement or resistance against the treatment program. Affordability, consumerism, lack of government hospital providing physiotherapy and the age related attitude are considered to form the patient’s resistance in this conversation. The conversation below given was between the female intern therapist (age 20s), the patient (age 60s) and his wife (50s) from low socioeconomic status. The patient came to the outpatient department in a wheelchair, he had a leg fracture. He came to the department for the follow-up, following a referral by the doctoral reference.

***PTR5: Epo walkerinnu crutchilekku maran samayamay. Eniepo oru crutch vanganam.***

***Wife: Patientinenokki kannadachukanichu annittu venda yennu thala anakki***

***Wife to patient: appo nammal crutch vangunnillae***

***P2 to Wife: Illannu sound undakki***

***PTR5: Ningalu crutch vangunnillae***

***P2: Athinte avasyamilla. anikku malker mathi***

***PTR5: Doctor walkerinnu crutchlottu marananu azhuthiyrikkunnathu. Departmentile crutch vechu Njan angananu ndakendathennu padipuchutharam. Cutchu vanguvanel apo athu help cheyyum... hmm? (Wifenyum patintenyum nokkunnu)***

***Wife: athe annu thala kulukki***



**(PTR5 crutch vechu nadakkunaathu angane anennu padipikanay avare exercise area illekku kottikondupy. Moonu perum exercise areailekku nadannu nigi)**

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***PTR5: This is the time to change from walker to crutch. Now you need to buy a crutch to walk***

***Wife look at P2, then patient blink the eyes and nod his head like no)***

***Wife to P2: Then, do not we buy crutch?***

***P2 to Wife: making sound like no***

***PTR5: Do not you buy crutch?***

***Patient: That's not necessary. Walker is enough for me.***

***PTR5: Doctor wrote to change the walkers to crutch. I will teach you how to walk with the crutches by using crutch in our department. If in case buy crutches then it will help you... Hmm? (Look both bystander and patient)***

***Wife: (nod the head like yes)***

***(PTR5 directed them to exercise area to teach how to walking with the crutch. Three of them move towards the exercise area)***

In the above example when the therapist asked about buying crutch (*Do not you buy crutch?*) then the patient expressed his resistance in the form of an indirect speech act (*That's not necessary. Walker is enough for me*). Speech acts may be direct or indirect. From the line *Do not you buy crutch?* it is clear that the intention of the therapist to confirm the decision of the patient through a yes or no answer. At that time, the patient was not answered directly (yes or no); but indirectly patient illustrated the ground of resistance by using the lines *That's not necessary. Walker is enough for me*. This kind of answer provided sufficient

information to the therapist to interpret it as a resistance from the side of patient and the therapist handled the resistance by mention that it (the crutch) was prescribed by the doctor. This can be seen in the line '*Doctor written to change the walkers to crutch*'. The similar response expressed the ten years experienced male therapist in the previous conversation while the patient showed his resistance against the treatment program. Both therapists referred to the higher power (doctor) to convince the resistance made by the patients.

Here, the old age patient showed resistance to buying crutches, for the treatment progression. As discussed in extract one, the age-related attitude could be a factor that influenced P2's decision making in that situation.

The conversations in extract two was also taken from the context of the private sector. So, the consumerism related to this conversation should evaluate. The consumerism provided the therapist-patient relationship with a different dimension which is different from paternalistic or a complete mutual framework. But it is likely to be difficult for patients to 'demand' rights and value for money to health professionals in the private health sector (Wiles & Higgins, 1996). It is not only because of the 'knowledge gap' between doctor and patients that constrained the development of consumerist relationships, but also the provider has personal and intimate knowledge about the patient and they were dependent on the therapist for treatment and care (Wiles & Higgins, 1996).

Consumerist attitudes to health care suggest new power relations with patients having greater autonomy than the professional. The power of consumerism may lead the patient to choose the decision not to buy crutches for future use. In extract 2 it is clear that the therapist was aligned with the patient opinion (*'I will teach you how to walk with the crutches by using crutch in our*

*department. If in case buy crutches then it will help you'),* but it could not be identified as an approach of completely accepting the patient power of consumerism or PTR5 not accepted the decision of P2 completely. This can identify from the lines *'I will teach you how to walk with the crutches by using crutch in our department. If in case buy crutches then it will help you'*.The P2 in extract two was from a low socioeconomic background. PTI15's perspective on the compliance of patients with low socioeconomic status (SES) while attending the private sector is quoted below:

*'Low socio-economic people they calculate money first then they think treatment section or about to buy equipment's necessary for their treatment'* (PTI15).

According to PTI15, the money is considered as a determinant of patient compliance. The previous studies identified that patients from lower SES, in general, have been associated with non-compliance to treatment regimens for asthma, juvenile rheumatoid arthritis, and renal disease (Bobrow, Avruskin & Siller, 1985; Denson-Lino et al., 1993; Brownbridge & Fielding, 1994; Rapoff et al., 2009). Studies relate to rehabilitation settings also described the relation between SES and non-compliance. For instance, low SES emerged as a predictor of non-compliance in Jackson et al. (2010) study in cardiopulmonary rehabilitation settings.

Lack of physiotherapy treatment provided by government sectors could be the reason to direct the low socioeconomic people to attend the private sector. The P34's words explained the situation that led her to attend the private sector. P34 said:

*'There is no government hospital near to my house providing physiotherapy treatment'* (P34).

So in this situation, people were forced to attend the nearby or accessible private hospitals for physiotherapy treatment for their necessary situations. Later on, this may have led to the possibility of non-compliance or discontinuing the full treatment because of affordability. More government hospitals with physiotherapy units were considered as a solution for avoiding this kind of situation.

The issue of unavailability of physiotherapy treatment in the local government hospital also discussed during the interview of P26.

*'Yes, there is a government hospital in Pangapara. That's near my house. But, the physiotherapy treatment is not available there'. So I have to spend a lot of money for travel in this jobless situation'. (P26).*

Here, P26 explained his struggle to attend a government hospital that provides physiotherapy treatment and this kind of struggle could be influenced the patient compliance. So, P26 quote also illustrates the necessity to introduce the physiotherapy treatment units in local government hospitals for the people in Kerala.

### **Extract: 3**

In this example, an argument happened between therapist and patient regarding the necessity to comply with the treatment program. The patient in this conversation showed a resistance to adhere to the treatment program. However, later she convinced mainly because of the affordable cost. The conversation was among the head of the physiotherapist in the MTH hospital in his 50s, the junior young female physiotherapist in her 20s and a young female patient in her 20s.

***PTJ1: OK. Nnayttu exercise cheyyanam. Allengil proper aytta nadakkan pattilla***

***P4: Enikku nadakkan pattum. Njan nallapole nadakkunnundu***

***PTJ1: Ithrayum stiffness ullapol arkanu proper aytta nadakkan pattunnathu? Ea stiffness vachittu arkim proper aytta nadakkan pattilla. (Smile)***

***P4: smile***

***PTJ1: At least one week angilum evide vannu exercise regular aytta cheyyanam.***

***P4: orazhchy? (Look at mother)***

***PTJ1: Njan veettinu aduthulla oru physiotherapy clinic il cheyamo***

***PTJ1: athu OK.***

***P4 to PTB2: Evide ethraya fees?***

***PTB2: 100 per day***

***P4: ahhaa. 100 rupeesye ullu. Apo kuzhapammilla. (Look at mother). Njanivide varunnengil apo varanam?***

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**PTJ1: OK. (You) have to do proper exercise regularly. Otherwise, (you) can't walk properly**

**P4: I can walk... I walk very well**

**PTJ1: With these much stiffness who can walk properly? Nobody can walk properly with this stiffness. OK? (Smile)**

**P4: (Smile)**

**PTJ1: You need to come here and do exercise at least One week regularly**

**P4: One week? (Look at mother)**

**P4: Can I do exercise there a physiotherapy clinic near to my home?**

**PTJ1: That's OK**

**P4 to PTB2: How much is the fee here?**

**PTB2: 100 per day**

**P4: ahaa...Only 100 RS/day. Then it's OK (look at her mother). If I come here what time I have to come here?**

It can identify a paternalistic way of approach from the side of the head therapist to the patient in many of the situations in this conversation. This is projected in several lines of this conversation. For example 'OK. You have to do proper exercise regularly. Otherwise, you can't walk properly'. The paternalistic approach could be considered as the power that used by the therapist to facilitate the healing of patient (Defibaugh, 2014). The patient answer (*I can walk... I walk very well*) can identified as an argument to what the therapist said. This may be communicated with the intention to resist the treatment program. Here, the patient was a young patient. According to the perspectives of the interviewed therapist compared to the older people young aged patients are more compliant with the treatment. Here is an example;

*'Young patients, middle aged patients do exercise properly. .However people after 65 or near to 70 will think there is no use to do exercise at this end stage. So, they do not adhere with the exercise'. (PTR11)*

However, the previous literature of physiotherapy had conflicting evidence on patient age and exercise adherence. For instance, Ay et al. (2016) study among osteoarthritis patients found that older patients were slightly more comply with home based exercise than younger patients. However, Lorenc and Branthwaite (1993) found in the case of osteoarthritis people over 65 years old were found to be less compliance than the young ones.

So, some other reason could be associated with the patient's resistance. This is more evident in the later session of this conversation. For instance, the patient asked PTJ1 *'Can I do exercise there a physiotherapy clinic near to my home?* Then the therapist agreed with the patient's decision. But, suddenly patient asked about the treatment cost (*How much is the fees here?*) and the treatment cost mentioned by the junior therapist was affordable for her. Then she quickly changed the decision to attend the clinic for the treatment program (*ahaa...Only 100 RS/day. Then it's OK (look at her mother).* If I come here what time I have to come here?). From this evidence, it can identify that the affordability may be the main reason for the patients non-compliance. So, in this sense, this could be an extract, which is similar to extract 2. In this extract, a consumeristic power from the patient's side and the age and professional related power can be identified from the therapist side. However, this example illustrates rather than the age related attitude from the patient's side a consumerist attitude, which depends on patient affordability could be the reason for her initial resistance. That is the patient affordability or the financial status could be a factor that influences the patient to use a consumerist power or to select the treatment.

Even if the therapist was used the paternalistic approach in certain situations the therapist took negotiations with the patient and attempts to make it friendly. For instance, it can see in the line *'With these much stiffness who can walk properly? Nobody can walk properly with this stiffness. OK (smile)'*. The therapist smile at this situation made it friendly and convincing. The therapist used negotiations with the patient, it can saw in the line (P4: *Can I do exercise there a physiotherapy clinic near to my home? PTJ1: That's OK*). That is even the therapist was in a powerful position (as a head of the physiotherapy department), the therapist listened to the alternative option provided by the patient and negotiated with the patient (*That's OK*).

### **6:2:2 Compliance**

Certain patients used critical reflexive and compare their previous experience as the interactional features to express their interest in compliance to the treatment and therapists were illustrated a paternalistic attitude and reassurance to support their decision. These were identified to building the rapport between patient and therapist. Extract 4, 5 and 6 used to explain the subtheme compliance explain. These extracts associated with compliance identify the interactional features, associated contextual factors and the power relationships that significantly influence on therapeutic relationship.

#### **Extract: 4**

This conversation was between the head of the physiotherapy department in his mid-50s and the female old age patient in her early 60s. This was their first time interaction. In this extract patient and therapist discussed the treatment compliance. Initially, the patient expressed the challenges to compliance with the treatment when the therapist explained about the treatment course to the patient.



So, the readiness of act (compliance with the treatment) from the patient's side was invisible initially because of the expressed challenges to attend the treatment. However, later the patient response illustrated her interest to compliance with the treatment become visible and this change in patient's interest could be related to the negotiation strategy that noticed from the therapist side.

**PTJ1: Ningalku 5 days physiotherapy treatment vendi varum. Oru equipment equipment upayogichu cheythulla treatment anu. Veedu evideya?**

**P10: Thopumpadi**

**P10: Eniku 5 days treatment veno. Ente veetil arum ella. Kuttikalokkae abroad anu. Njn travelline kurichanu chinthikkunnath.**

**PJ1: (Thalla attunnu). Veettinu aduthu physiotherapy ulla anthenkilum clinic undengil avide phsyio cheyyam.**

**P10: Avide Enikku local ayttulla physio clinic onnum ariyilla.**

**PJ1: Sthalam avideya?**

**P10: Thoppumpadi**

**PJ1: Jacob nursing home ariyamo?**

**P10: athe. Avide physiotherapy treatment Undo?**

**PJ1: Yes, ningalku avide pokanamengil avide pokam. Allengil evide varunegil 5 divasam varam. Otherwise no use. Nigal theerumanikku.**

**P10: Evide varunekil njan businu varanam. Rush kuravulla samayathu varanam. I can't come on autoriksha ee stageil....hmmm**

**PJ1: Ningalku diabetic's ullathu alla. Adyam lunch kazhikku ennittu decide cheyyu OK?**

**P10: Athu saramilla. Njan evidevarunnathinu thottu munbu chayayum biscutum kazhichathe ullu. Njan evide varunengil apo varanam.**

**PTJ1: moring oru 10 o'clock allengil evening varanam.**

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***PTJ1: You need to do physiotherapy treatment for 5days. An equipment is used to give you that treatment. Where is (your) house?***

**P10: Thopumpadi**

**P10 do I need to do 5 days treatment. I do not have anybody in my house. Children are abroad. I think about travel**

**PTJ1: (nodding head like yes). If you know any physiotherapy clinic near to your home (you) can do physio there.**

**P10: I do not know about local physiotherapy clinics there**

**PTJ1: where is your place?**

**P10: Thopumpadi**

**PTJ1: Do (you) know Jacob nursing home?**

**P10 Yes, is there physiotherapy treatment available?**

**PTJ1: Yes, if you want you can go there and do the physiotherapy there. Or if you come here you need to come 5 days, otherwise no use. You decide.**

**P10: If I come here I need to come on bus. Need to come less rush time.**

**I can't come in autoriksha at this stage.....hmmm.**

**PTJ1: You have diabetics. Right? So have your lunch first. Then decide. OK?**

**P10: That Ok: I had my tea and biscuit just before came here.**

**Patient: If I come here what time I have to come?**

**PTJ1: Morning 10: 00 clock or come evening.**

Here, the therapist asked 'where is your house?' to the patient may be with an intention to know about her accessibility to the clinic, which in turn considered to influence the patient compliance. The patient's answer provides the evidence of it (*Do I need to do 5 days treatment...*). The patient raised her concern about the travel without a caretaker. Therapist perceived this concern as a challenge to the given suggestion to attend the clinic. It is evident in the therapist reply '*If you know any physiotherapy clinic near to your home you can do physio there*'. This reply of the therapist could be considered as an initiation to solve the perceived

challenge. It can also be identified as a form of negotiation strategy from therapist side by probing the possibility of an alternative option for the patient to attend the clinic. From the following conversation it can be noticed a collaborative interaction between patient and therapist to find out an accessible clinic for her treatment (*PTJ1: where is your place? P10: Thopumpadi PTJ1: Do you know Jacob nursing home?*). From this collaborative effort and from the line '*Yes, is there physiotherapy treatment available?*' it can be evident that the patient's interest to attend the clinic.

Here, the therapist provided the possible options to the patient, to compliance with the treatment ('*yes, if you want you can go there and do the physiotherapy there. Or if you come here you need to come 5 days, otherwise no use*'). Then, leave it to the patient to take the decision in a patient centred way. This is an excellent example of how to sharing power in decision making. So a mutual power relationship can visible in this interaction. Therapists in this extract also conducted a caring and friendly interaction with the patient (*You have diabetics. Right? So have your lunch first. Then decide. Ok?*). This possibly enhances the therapeutic relationship (Hush, 2011). At the end of the interaction, the patient interrogation about the clinical attendance could be identified as an interest to attend the clinic and compliant with the treatment ('*If I come here what time I have to come?*'). The intention to ask this question could be arises as a result of the positive behaviour (negotiation, collaboration, friendliness and caring) that he experienced from the therapist.

### **Extract 5**

The situation in the below interaction was about the patient's history taking and examination by the therapist just before providing the treatment and the

conversation was an example of patient's positive response to compliance with the treatment program. The generic structure of the below conversation was a medical interview. The knowledge sharing or knowledge exchange is the speech function happening in this section. The particular conversation given below was between the male therapist (age late 30s) and the female patient (age late 50s). The patient came to the outpatient physiotherapy section with chronic shoulder pain followed by the referral from the physiatrist.

***PTS10: Eanthupatti?***

***P11: Shoulder pain anu ,epo vedhana radiate ayettu ethuvare undu. Njan pala doctorsineyum kanichu oru kuravum ella.***

***PTS10: OK kidanno, assess cheyyanam***

***(P11 kiddannu, PTS10 vedhana ulla area palpate cheyyan thudangi)***

***P11: AHAA...***

***PTS10: Ethra thamasichathentha epo ethu chronic ayallo***

***P11: Oru private Ayurvedic clinic poyarunnu. Thriveni. Onnu onnara masam avaru avide ullichillum pizhichillum allam nadthi. Pakshe painu oru kuravilla ante paisaum othiri waste ay.njanj evide vannapo physiatrist ante adukkal chodicharunnu ningaloru nursallayrunno pinne annathina ayurvedhathil poyennu.***

***PTS10: Nurse ayrunno?***

***P11: Athe. Epo retired ay.***

***PTS10: Avida workeythirunnathu?***

***P11: Evide Medical college il.***

***PTS10: Njan evidennu fascia release cheythutharam veetil poy exercise cheyyanam***

***P11: aykottae***

***PTS10: Fascial mobilisecheyyan thudangi***

**P11: AHAAA.....pain undu**

**PTS10: Ethuepo theerum**

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**PTS10: What happened?**

**P11: Shoulder pain and pain radiates up to here (point out the middle of the arm). I showed different doctors it does not reduce**

**PTS10: Ok lay down, Want to assess**

**(P11 lay down and PTS10 starts to palpate the trigger area)**

**P11: AHAA...**

**PTS10: Why you come late, now it becomes chronic**

**P11: Went to a private Ayurveda clinic .Thiriveni .They gave pizhichil Uzhihil and all for the last one and half month. But the symptoms do not reduce and my money also becomes waste. When I came here the physiatrist asked me wasn't you a nurse? Then, why I went Ayurveda?**

**PTS10: Wasn't (you) a nurse (keep palpating the area)**

**P11: Yes, Now retired.**

**PTS10: Where were you worked?**

**P11: Here in Medical College.**

**PTS10: I will release the fascia here and you need to do the exercise at home. OK?**

**P11: yes**

**(PTS10start to mobilise the fascia)**

**P11: AHAA... it's paining**

**PTS10: It will finish soon.**

In the first section of the conversation, it is apparent that the therapist was taking the medical history of the patient by using interrogative mode. When the therapist entered into the physical examination the mode was changed to a demand (*lay down, Want to assess*), which typically realised as positive imperative clauses.

A speech act response identified in the line starting from '*why you come late? Now it becomes chronic*'. This seems to be a judgment (indirect) from the side of therapist about patient current disease condition rather than a simple history taking. In indirect speech act, one speech act is performed indirectly by performing another (Searle, 1985). The line '*why you come late?*' was an expression of interrogative mode, so obviously, the goal was to get an answer. However, a criticism on patient irresponsibility to present the clinic on time (before the condition become chronic) was performed indirectly by performing another communication act – asking about the patient's reason to attend the clinic on time ('why you came late?')

The next sentence ('*now it become chronic*') was directly performed as an assertion from the therapist's side. In that, the therapist assertion regarding the patient's severity of the disease could be based on his previous experience with similar (chronic) conditions. But, an indirect act of disclosure from the therapist's side about the perceived difficulties (negative side of the present condition) which can happen while treating a patient with chronic condition (for instance therapist effort to mobilize the fascia in such chronic conditions or the pain intensity that the patient has to tolerate while mobilizing a chronic musculoskeletal condition) was also seen in that line.

In the above mentioned speech act the irresponsibility of the patient to attend the clinic on time (*'the condition become severe or chronic'*) is considered as the illocutionary force. The illocutionary force of an utterance is the speaker's intention in producing that utterance (Oishi, 2006). That is the therapist produce the utterance *'the condition becomes severe or chronic'* with the intention to point out the patient's irresponsibility to attend the clinic on time.

The directive speech act can see a couple of section of this conversation which includes the lines starting from *'ok lay down, Want to assess'* and *'I will release the fascia here and you need to do the exercise at home. OK'*. These lines illustrated that the therapist wanted to apply some condition to the patient in the form of commands as a part of treatment and assessment.

In this extract, the professional power from therapist side made an imbalance in power relationship between patient and therapist. This could be identified through the lines

*'why you come late, now it becomes chronic'*

*'ok lay down, Want to assess'*

*'I will release the fascia here and you need to do the exercise at home. OK',*

The knowledge, social status and gender of both subjects need to be considered to identify the form of power that exerted in this particular situation. The therapist interacted as an expert in the above mentioned lines; so while interacting with the patient therapist's used his power of knowledge. A kind of paternalistic style of power relationship can be seen in this interaction especially the line starting from *'I will release the fascia here and you need to do.....'* It be could considered that the therapist's used the power to facilitate the healing of patients. According to Smith and Beutow (2001) how power is used and exchanged is influenced by the personal qualities of the therapist and patient.

Here, the therapist used his senses of confidence through the line starting from 'I will release....' this may be influenced the patient to compliance to the treatment program to relieve her shoulder pain in its chronic stage. Previous studies conducted in a physiotherapy context identified that the therapist confidence as a factor that influences therapeutic relationship and patient satisfaction (Bachelor, 2013; Synnott et al., 2015); thereby it possibly increases the chance of patient compliance.

The patient response to the therapist question ('why you came late?') seemed to be a critical reflection on her previous experiences in traditional medicine. This can see in the line '*The symptoms does not reduce. My money becomes waste*'. The critical reflection is considered as the positive response of the patient to compliance with the physiotherapy treatment. During the semi-structured interview, P24 is provided with the same kind of opinion.

*'I did ayurvedam before. I spent a lot of money for that. I paid 600rs/day. In addition to that buy lot of oils and all for massage. But the pain didn't reduce. Here, I attended the physiotherapy treatment 6 days. Now after the physiotherapy treatment the symptom get reduced'* (P 24)

Here, P24 illustrated critical reflection regarding her initial decision to attend the ayurvedic clinic. P24 critical reflection on her non reducing symptom and wastage of money for the ayurvedic treatment could be the reason encouraged her to compliance with physiotherapy treatment. So, the patients, who illustrate a critical reflection could be considered as the positive response to compliance with the physiotherapy treatment.

### **Extract: 6**

The conversation below given is an example of patient demonstrating self-motivation to compliance with the treatment regimen. The interaction took place



during the time of the treatment section. The patient in this conversation had been referred by the orthopaedic doctor to the outpatient physiotherapy department for post-surgical physiotherapy treatments. The conversation was taken from an outpatient physiotherapy department of a private hospital and the interaction was between an intern female physiotherapist (age 20s) and a male patient (late 30).

***PTO4: Vedhana thonunundo? (PT03 finger mobilization technique kodukkunnu).***

***P3: Ethonnum sherikkum ulla vedhana alla. Vadahayokkae njan anubhavichathu aa dhivasamallae accident undaya dhivaam. Orudhivasam muzhuvan njan pain thinnu.***

***PTO4: smile***

***P3 : Vedhana oru prashname alla. Anikku ante epozhathe avastailnninnu kerivaranam. Ante kai pazhayathu pole anikku normalayttu upayogikkam.***

***PTO4: Sheriyakum. shrikkum alla excercisum cheyythal kai pathuke functional aykolum.***

***PTO4: Do you feel pain? (PTO4 providing finger mobilization technique)***

***P3: This is not a real pain.... Pain I felt on that day the accident happened day... I ate the pain whole day.***

***PTO4: Smile***

***P3: Pain is not at all a problem... I need to recover from my this situation...I need to use my hand normally***

***PTO4: Will be alright. Hand will slowly become functional after doing all the exercises regularly.***

As the patient-therapist interaction is a collaborative effort of both participants, in the above conversation the therapist used an interrogative mode to know about the severity of pain while giving the treatment (Thornborrow, 2002). The intention may be to modulate the treatment according to the response from the patient's side and the answer expected would have to be yes or no on the basis of the given form of the question. But, the patient utterance was not a direct

answer. Instead of that, the patient indirectly expressed his unbothered attitude towards pain by comparing his previous experience of the pain that he experienced on the day of the accident. Even though it was an indirect response from the patient's side it provides sufficient information to the therapist that the therapist can compute a direct answer of 'yes' to her question.

Also, the patient considered recovery as his self-need and expressed it as a distinctive form of motivation. This is apparent in the line that starts from '*pain is not at all a problem*'. This motivation considered a positive act to comply with the treatment program. This form of patient attitude is entirely opposite to the attitude that we saw in the first example (old patient's resistance attitude). There the conflicting ideology from the patient's side made a clash with the philosophy of physiotherapy. However, here in this example (Extract 6) the high motivation of the patient to take the active role in his current situation or the awareness about his own responsibilities, that creates a compatibility with the philosophy of physiotherapy.

When considering P3's identity, P3 was a driver and the main bread earner of his family. Below quoted the PTB19 views about the relationship between pain tolerance and socioeconomic status

*'Also I felt the patients coming from low social level seems to tolerate the pain at their maximum for improvement. I think this is for getting faster improvement... then only they can go back to work'* (PTB19)

According to PTB19 patients from low SES had better pain tolerance level. Very few studies had investigated the relation between pain tolerance and SES (Krantz & Ostergren, 2000; Milijkovic et al., 2014). In this none of the studies found patient from low SES had better pain tolerance level (Krantz & Ostergren, 2000; Milijkovic et al., 2014). Interestingly there were studies that identified the

effect of patients' pain tolerance on their compliance with the physiotherapy treatment. Previous studies related to patient's pain tolerance find out that injured sports people with a high pain tolerance were significantly more likely to be compliance with the programme requirements than those with a poor tolerance (Fisher, Domm & Wuest, 1988; Fields et al., 1995). Potter, Gorden and Hammer (2003) explored from therapist's perspective patient's level of pain tolerance as an important factor that influenced therapeutic relationship. During the time of interview, PTR17 shared the experiences on how patient's level of tolerance influenced her in the clinical practice.

*'Certain patients have less pain tolerance level. This types of patients are very hard to handle. Can't give proper treatment to such kind of patients... I can say this affects the patient-therapist relationship'. (PTR7)*

On the basis of above explained evidence the level of pain tolerance could be considered as a factor that influenced treatment compliance as well as the therapeutic relationship. Self-motivation is an important matter that can be identified in extract 6 in relation to compliance. During the time of interview, P26 describes his motive behind exercise compliance and is given below

*'I am not going to the job now, I want to go back to my job. So I do follow the exercise and everything that what sir, saying' (P26).*

Here, the P26's motivation was an example of more autonomous or self-determined form of extrinsic motivation through identification of his future goal as to go back to work (Chan et al., 2009). Similarly, P3's motivation might be considered as an extrinsic motivation aroused as a result of his external identification behavioural regulation. Identified behavioural regulation is a form of extrinsic motivation refers to a person performing an action because he or she values the benefits that will be derived (Ryan & Deci, 2000). Here, both patients

were the bread earner of the family, from low SES and their identified social responsibilities made them more compliant with the treatment. PTM9 also expressed the similar opinion,

*'When considering the case of low socioeconomic family or a borderline middle-class family... usually, the men in the family were the main bread earner ...and the rest of the family usually depend on that man. So such kind of patients usually seems to be highly self-motivated'. (PTM9)*

According to PTM9 the life situations of the patients from low SES or borderline middle-class family might be acted as an external factor for their self-motivation. This possibly encouraged patient compliance with the treatment regimen and thereby create a positive relationship with the therapist.

The therapist in this extract provided empathy to the patient in the form of alignment and reassurance. After the patient explained about his pain experience the therapist smiled. This could be considered as an act of alignment from therapist side to the patient. A reassurance talk can be seen in the line *'will be alright'*. The reassurance could be based on the assumption that the patient will cooperate with treatment.

A form of patient education can see in the line starting from *'Hand will slowly become'*. That also can be considered as an effort from the therapist's side to make the patient understood the real fact about his prognosis rather than being over optimistic. The evidence of power imbalance between patient and therapist could not be identifiable in this conversation. A mutual give and take therapeutic relationship can see in this conversation. That is, expression of feelings from patient side and an empathetic as well as an educational approach from therapist side. This was identified as a positive aspect of this interaction.

### **6:3 Summary of the findings associated with compliance and therapeutic relationship**

Table 6:1 illustrated the synthesis of relevant findings identified in each stage of data analysis associated with patient compliance and the therapeutic relationship.

Patient's direct (speech) and indirect (speech) resistance to comply with the treatment is interpreted in the different situation discussed in this chapter. For example, according to this study patient's expressed belief (Karma-phalam) could be considered as an indirect response to resist the treatment. In such situation, therapist's indirect speech could be considered as a way to make the patient compliant to the treatment. For instance, in terms of referring higher authority by the therapist. Patients, who were compliant with the treatment illustrated critical reflexive discourse and discourse of self-motivation (comparing previous experiences); this kind of discourse in this particular context identified as to facilitate the therapeutic relationship.

In certain situation, therapist's assertion and indirect judgement to encourage the patients compliant to the treatment eg: *now it becomes chronic*'. Also, therapist's reassurance and alignment towards the patients identified as the interactional strategies that enhance patient compliance. Patient's desire to cooperate with treatment and therapist's positive attitudes (empathy, confidence and negotiation) was interpreted as the institutional factors that enhanced the

**Table 6:1. Synthesis of findings of chapter 6**

Subtheme	Textual	Interpretive	Explanatory
Non-compliance	Patient's resistance through indirect speech (In terms of expressed belief)  Therapist used Indirect speech(In terms of referencing higher authority)  Patient's direct speech of resistance (direct refusal ' I do not want to walk)	Expressed opposing ideology of philosophy behind physiotherapy  Affordability Accessibility  Pain related issues	Consumerism  Patient's and therapist's age-related attitude
Compliance	Patient's critical reflection  Alignment Reassurance  comparing previous experience  Assertion and Indirect judgement  Provide alternative option	Therapist's confidence  Empathy  Patient desire to – cooperate with treatment   Negotiation	Paternalism  Mutuality

patient's compliance with the treatment as well as it created a positive therapeutic relationship. However, patient's affordability, physiotherapists in adequately act

the professional role as expertise (in patient education), patient's accessibility issues (especially, lack of physiotherapy providing government hospitals), opposing ideologies from patients and patient's less pain tolerance or fear of pain were considered as elements leading to non-compliance. Consumerism and age-related ideological power possessed by patients created an imbalance between patient and therapist power relation, which in turn negatively affected the therapeutic relationship and led to patient's resistance to the treatment program. Paternalist kind of approach from therapist's side towards patients in a positive way (aimed to facilitate the patients healing) considered as enhanced the therapeutic relationship. Also, the mutual power dynamics between patient and therapist appeared to encouraged better therapeutic relationship and thereby facilitated patient compliance.

#### **6.4 Chapter summary**

This chapter discussed the linguistic features, professional contextual factors and the wider socio-cultural factors associated with patient's compliance and the therapeutic relationship. The discussions were conducted by using the natural therapeutic interaction obtained from the research settings along with the patient and therapist individual perspective about this topic. As given in table 4 certain linguistic features were identified during the patient-therapist interaction; some specific underlying power relationships were found and associated contextual factors also interpreted. These might be the elements that influenced the therapeutic relationship as well as the patient compliance or non-compliance.

## **Chapter 7: Solidarity and Therapeutic Relationship**

## **7:1 Chapter introduction**

This chapter explains the interactional features, the contextual factors and the power relationship associated with the solidarity-forming conversation and how such kinds of conversations influence the therapeutic relationship in Indian physiotherapy settings. The chapter comprises two sub themes: medical related shared narrative and non-medical related shared narrative. Six sample extracts from the audio recorded interactions of patient-therapist are used to illustrate these subthemes. The extracts consist of the solidarity-forming conversation between patient and therapist during the time of treatment sessions. The therapist and the patient perspectives that were obtained from their interviews (conducted in both first and second stage of data collection) were also used as the supportive resource to interpret the extracts. This chapter is concerned with the introduction about the importance of solidarity talk in the medical context to improve the therapeutic relationship, analysis of the extracts, synthesis of results obtained from textual, interpretive and explanatory stages of analysis and a summary at the end.

## **7:2. Enhancing solidarity talk in the therapeutic relationship**

Power and solidarity are not new topics in the field of sociolinguistics (Brown & Gilman, 1960; Tannen, 1994). However, in medical settings despite the larger body of research on the discourse of power, research on solidarity is rare. The existing research on solidarity is specifically based on physician-patients, or nurse- patient's interactions (Grainger, 2004; Li et al., 2007; Defibaugh, 2014). But, in the physiotherapy context, there is no published research which specifically focuses on solidarity.



Solidarity is generally considered as a communicative approach to improve personal relationships and is defined as the unity or agreement of feeling or action, especially among individuals with a common interest (Oxford dictionary, cited in Defibaugh, 2014). Individuals may express their feelings, attitude, opinions or belief which are indicative of an orientation towards solidarity (Koester, 2006). The core intention of individuals expressing solidarity is mutuality. The individuals convey their solidarity in different ways, which include expressing approval, showing interest, sympathy or claiming common grounds (Koester, 2006). In the health care context, solidarity in conversations can attain various aims. For instance, it is used as a simple way for a medical professional to find out more about the patient which is relevant for the diagnosis or treatment or it is used as an attempt to reduce social distance (Defibaugh, 2014). Also, solidarity approaches provide the patient with the opportunity to share their power and orient to their identities as individuals or to their 'non-patient' identity (Defibaugh, 2014). This kind of opportunities helps to convey mutuality in the therapeutic relationships. Health professionals have been reported to use different communication techniques to foster solidarity. For example, Grainger (2004), in a study involving nurses, identified that humour was used to create solidarity as well as maintain the power distance with patients in a geriatric ward. Defibaugh (2014) found that nurses were encouraged patients to share narratives during the medical visit to creating solidarity with the patients or the use of 'we' and 'our' in the talks focused on decision-making and treatment options signifying a stance of shared benefit and joint ownership of decisions. The evidence illustrated that health professionals expressed solidarity towards patients. This may be help in creating better therapeutic relationships.

This chapter explains the interactional features the contextual factors and power associated with the patient-therapist conversations on solidarity in an Indian physiotherapy clinical setting. It also, describes how the conversations on solidarity influence the therapeutic relationship.

**Shared- narratives:** Sometimes health professionals encourage the patient to share narratives during their medical visit and this is considered as a form of building rapport and creating solidarity with the patient (Defibaugh, 2014). The topics that encouraged the patients to be discussed during the interaction may or may not be related to the patient's disease. Extract 7, 8, 9 10, 11 and 12 are the examples of therapist's expressing solidarity in the form of alignment with patient's shared narratives. Two kinds of 'shared narratives' found in this study includes medical related shared narratives and non-medical shared narrative, which is based on the topic that the therapist encouraged the patient to share.

### **7: 2:1 Medical related shared- narratives**

Extract 7, 8 and 9 are the examples of the subtheme medical discussion in which the therapist encouraged the patient to share their medical related topics during the interaction.

#### **Extract: 7**

In this extract, the therapist encouraged the patient to share the narrative that was related to the patient's condition. Here, the therapist may be expressed his solidarity to support the patient's attitude towards Ayurvedic medicine. The interaction was between a male therapist and a male patient both in their late 30s. The patient in this extract was a Chikungunya survivor [Chikungunya is a viral disease transmitted to humans by infected mosquitoes; fever and severe joint pain are its main symptoms. Most patients recover fully, but in some cases, joint

pain may persist for several months, or even years (WHO, 2017)]. Now the patient had secondary joint complaints and attended the clinic for the follow-up treatment.

**PTU8: Apozha sherikkum chicken –gunya vannathu**

**P15: 2006 ill undaya outbreakil. Aa samayathu orupadu pere evide eante koode admit cheythayirunnu 2006 ill. Ea asughavumayttu Medical College ill admit cheythavarill mikavarum eallavarum marichu. Athukondu aa samayathu Anikku bhyangara pediayrunnu.**

**PTU8: (chikithsa thudarnnukondirunnu, shredhikkunna tharathil thala attikondirunnu)**

**P15: Aa samathu discharge cheythashesham njan hospitalill ninnu oru ayurvedha ashupathri ill poy. Avide avar oil vachittu complete treatment cheythu. Orutharathillulla oru ayurvedha treatment.**

**PTU8: (Chikithsayku edayill samsarikkunnu) Oru prethekatharam marunnundu ayurvedhathil. Hmm...njan thu T.V il oru documentary ill kandathanu. Avaru parajathu chicken- gunyayude bhagamayttu varunna joint problem thinnu allam athinu upayogichal gunamundenaanu. Yatharthhathill allopathic medicine pora ea condition maran. Anikku Ayurvedic medicinie patti sherkkum ariyilla. Ethil ningal atho chedi pallinte koode kazhikkanam athupole antho anu. Ningaloru proper aytulla oru ayurvedha doctorinte aduthu ethane kurichu choshilal mathi. Avaru ethumayttu bandhha petta advice tharum.**

**P15: Njan ayurvedha treatment cheythapol anikku nalla resultanu kittiyathu. Pakshe njan thirichuvannapol doctor athu valiya issue akki aduthu. Polli annodu bhayangara dheshya pettu. Pulli chodhicu anthina ayurvedhathil poyathu? Ningalkku ningalude rogathinnu ayurvedha treatmentanu kuduthal kollamennu thoniyathengil pinenthina annae kanan vannathu?**

**PTU8: (Chirikkunnu): Chilla doctor-mar Ayurveda prefer cheyilla. Yatharthhathill yurvedham chilla pratheka rogangalkku nallathalla. Annae sabandhhichu ningalku ningalude condition Ayurveda try cheyyam.**

***PTU8: when you exactly got the Chikungunya'***

***P15: In 2006 outbreak. At that time, many people were admitted with me here in 2006. Most of them admitted in medical college with this condition were died. So I was very scared at that time...***

***PTU8: (continued the treatment, nod the head as if he is listening).***

***P15: At that time, after discharged from the hospital I went to an Ayurvedic clinic in Tamilnadu. There they did complete treatment with oil. It's a kind of ayurvedic treatment.***

***PTU8: (talking while giving treatment) There is one particular medicine in Ayurveda. Hmm... That I saw on television in a documentary and they said it has the beneficial effect in joint problems associated with Chikungunya'. Actually, the allopathic medicine is not enough for reduce this condition. I am not sure about that Ayurvedic medicine. It is like you have to eat some kind of plants with milk. You asked a proper Ayurvedic doctor about this. They gave proper advice about this.***

***P15: Oh ... Ok. When I did that Ayurvedic treatment I got better results. However, I came back for a review then the doctor made it as a big issue and the doctor was very angry towards me. He asked me that "why did you go to Ayurveda? If you felt the Ayurvedic treatment is more effective for your disease then why do you come to see me?"***

***PTU8 (smiles): Certain doctors do not prefer Ayurveda. Actually, Ayurveda is not suitable for the certain disease. According to me for your condition, you can try Ayurveda.***

In the above conversation, the question '*when you exactly got the Chikungunya'*' was usually supposed to probe at the time of patient's assessment by the therapist; however, in this situation, it had been asked to the patient at the time of treatment session. So, the intention of that may be to encourage the patient to share the narrative. In addition to that the act of 'nodding head as if listening' was also considered as the way of encouraging the patient to share his past medical history.

During the conversation, the patient introduced the topic Ayurvedha. This can be seen in the line starting from '*At that time, after discharged from the*

*hospital.....'* And that was a form of a declaration from the patient's side about how the patient's condition linked with Ayurvedic medicine.

Then the therapist created an alignment with the patient narrative about the use of Ayurvedic medicine and this can be seen in the section of conversation starting from '*There is one particular medicine in.....'* It was conveyed by the therapist in different ways. Firstly, the therapist expressed his solidarity as an agreement to use Ayurveda medicine by referring the documentary program that he watched on the television ('*That I saw on television*'). Secondly, the therapist criticised the allopathic medicine to illustrate his solidarity ('*actually the allopathic medicine is not*'). This is considered as a positive response from the therapist's side or may be an encouragement to use Ayurvedic medicine. Also, the therapist expressed his solidarity by expressing approval to the patient to approach an Ayurvedic doctor for the proper advice ('*you ask a proper Ayurvedic doctor*').

Here, in this context, the therapist's show of solidarity could be interpreted as the therapist's act of encouragement to the patient's autonomy. The patient's autonomy enabled the patient to make autonomous decisions on the basis of the support and guidance provided by the health professionals (Entwistle, Carter, Cribb & McCaffery, 2010). This also allows the patient to take a decision without surrendering the medical power on which the patient depends. In this extract, the patient explained his previous experience about the traditional medicine ('*At that time, after discharged from the hospital I went to an Ayurvedic clinic in Tamilnadu*') to the therapist. Then, the therapist encouraged the patient to consider Ayurveda as a solid treatment option for his condition. This is identified as the therapist's act of providing treatment choices for the patient and thereby encouraging patient's autonomy. When the patient got such kind of encouragement from the therapist, the patient reflected upon his previous

experiences about the traditional medicine that he received for the same condition (*'When I did that Ayurvedic treatment I got better results'*). In this aspect encouraging the autonomy of another person, or patient in a clinical context, also a form of acknowledging an equality in the ability to self-reflect and make choices. Encouraging patient autonomy is a way of enhancing the therapeutic relationship and is considered as the core element of patient centred care (Entwistle, Carter, Cribb & McCaffery, 2010).

One of the factors needed in a process that creates trust between human beings is disclosure or transparency (Piippo & Aaltonen, 2008). It is closely connected to the behaviour of openness because disclosure requires that all parties give something personal to be shared. This is what is apparent in the line starting from *'However, I came back for a review then the doctor made it as a big issue ...'*. That is the patient revealed his personal experience on how the higher authority (doctor) behaved to him while the patient explained about the use of traditional medicine. This kind of openness (sharing the personal experience) from the patient's side might be considered as a part of the trust that the patient felt in the therapist. The alignment of views about Ayurvedic medicine in this conversation might be the reason behind the trust formed in the patient. Trust between patient and therapist is considered as an important factor in health care settings and it is only possible through a good quality therapeutic relationship (Leach, 2005). Helkama (2004) argues that trust is possible where there is an equal distribution of power. The abuse of the power is one of the factors that easily leads to mistrust. In health care communications, the lack of trust will mislead the interactions and provide the message that health professionals are experts and the patients are not competent to influence them in the decision-making process (Piippo & Aaltonen, 2008).

According to Helkama (2004), when people trust others to act fairly and honestly, there is no need for hierarchic and controlling power structures. In that sense, the power imbalance between therapist and patient could not be identified in this extract. The therapist may be showed alignment with the patient, as a part of encourage patient autonomy and the patient openness to the therapist was considered as the factors that helped to create mutuality in this conversation.

If the professionals were able to be open in their dialogue and talk about their own thoughts, the process between them and the patients deepened and became mutual and transparent (Piippo & Aaltonen, 2008). Here, it appeared that PTU8's willingness to discuss openly the effect of Ayurvedic treatment might have encouraged P15 to behave more openly about what he experienced previously in terms of Ayurvedic treatment and the behavioural consequence that he experienced from the doctor. This could be identified as an evidence of how mutuality and transparency build a therapeutic relationship. The therapist's encouragement of patient autonomy and the trust that the patient felt in the therapist were identified as the positive elements that enhanced therapeutic relationships in this conversation (Piippo & Aaltonen, 2008).

In extract 7, the therapist and patients mainly discussed the traditional medicine, Ayurveda. Traditional medicine is a part of south Indian culture and it was noticed as a frequently discussed topic in patient-therapist interactions during participant observation. So it is essential to discuss the role of traditional medicine within the interaction of patient and therapist in this particular context.

The next section discusses the therapist's and patient's perspectives about the Ayurvedic medicine and the role of traditional medicine in the conversations on solidarity. According to the interview data patients have a strong belief in

Ayurveda. So in that sense, in extract 7, the therapist showed his solidarity to the belief of P15. The quotes below drawn from across the research interviews provide a range of therapist's perspectives on patient's affinity towards Ayurveda.

*'In my opinion patients strong belief is the main reason to go behind Ayurveda' (PTC16)*

*'Many patients usually use ancient method like nattuvaidya or Ayurveda at first. Sometimes the condition, not cures or the condition becomes worse, then they come to us. That time the condition may be becomes chronic...because of that they can't even tolerate the pain. So in such situation, the pain becomes a problem for rehabilitation' (PTM9)*

*'We explain the merits and demerits of the Ayurvedic treatment for their specific condition and their current level of recovery...But still, certain people have the strong belief in Ayurveda... They, the Ayurveda people may not be known about the scientific side of the disease. But the people very happy with the treatment that they provide because the Ayurveda is a natural treatment method' (PTP18).*

*'Once they get 50% improvement almost 95% of patient's ask about Ayurveda regardless of their age or sex...or cast. Among them, some going to try Ayurveda and 10% of them will come back with the bad result' (PTC16).*

In the above quotes PTM9, PTP18 and PTC16 expressed the difficulties or the negative consequences that they usually experienced while treating the patients who selected Ayurveda as a treatment for their conditions. However, in extract 7 the therapist had illustrated a common ground with the patient while they interacting about Ayurvedic treatment. In that aspects, extract 7 could be considered as an example of how therapist make common ground with the patients regardless of their (therapist's) actual beliefs about Ayurveda. So, the evidence (conversations in extract 7) suggests that even if the therapists have a different opinion, a solidarity approach from the side of therapist possibly encourage the patient to talk about more openly (*'When I did that Ayurvedic*



*treatment I got better*). That is the solidarity approach from the therapist's side identified as a facilitator to bring the patient's open behaviour, which is necessary for forming a better therapist - patient relationship (Rosa & Hasselkus, 2005).

Patients shared their experiences about the responses that they experienced from the therapists while interacting about Ayurvedic treatment are given below.

*'Sir, said that doesn't go for 'thirumal'. Actually, I received Ayurveda treatment for a few years back for the same condition and I was satisfied with Ayurveda treatment and I like to continue Ayurveda treatment'. (P8)*

*'I discussed with him (physiotherapist) before. He told me the tailum use externally it does not give any internal recovery. So I understood about that fact and now I do not have any interest. But I do not know in future'. (P23).*

*'Sir, said there is no specific use for tailum. But I used tailum before came here, I took heat for the pain as well. Still, now I am using tailum for this pain' (P30).*

The above quotes reflect what the patient's felt while the therapist took an assertive or a non-solidarity approach regarding the use of Ayurvedic medicines. Most of the patients in the interview used Ayurvedic treatment initially or had an interest to use the Ayurvedic treatment in future. From the above quotes, it is clear that even though the therapist had a different opinion about Ayurvedic medicine the patient had a special affinity towards the traditional medicine in Kerala. So while interacting with the patients about Ayurveda a solidarity approach may be more helpful in creating a better therapeutic relationship rather than adopting a power of assertion.

At the end of this extract, a diplomatic approach can be identified from the side of the therapist. That is the therapist was distancing himself from the doctor, while at the same time aligning with the patient perspective. This is apparent in

*'Certain doctors do not.... you can try Ayurveda'*. Even after the realisation that the superior power (doctor) had a different opinion, the therapist clearly illustrated his individual opinion about using Ayurveda in this patient's particular condition. So from this, it is recognised that the therapist stayed on the patient's side without criticising either the Ayurveda or the allopathic medicine. The therapist also, provided a form of indirect justification to the patient regarding the higher authority opinion (*'certain doctors do not prefer Ayurveda. Actually, Ayurveda is not suitable for the certain disease'*). This could be a form of respect the therapist provided to the higher authority's opinion.

This diplomatic approach could be considered as the therapist professional skill to communicate effectively in this kind of complicated situation. That is, if the patient and the referral doctor have different opinion or opposing interest a diplomatic attitude could be suggested to the therapist to illustrate a mutual respect.

### **Extract: 8**

This extract is considered as an example of how the propositional act of assumption could be used to find out common grounds in the patient-therapist interaction. Fairclough (2003) considered common grounds are usually created by using the different kinds of assumptions. According to Fairclough (2003), assuming common grounds reduces the difference between subjects. He identifies three categories of assumptions that usually could be used the subjects to create common grounds: existential assumptions, or "assumptions about what exists"; propositional assumptions, or "assumptions about what is or can be or will be the case"; and value assumptions, "assumptions about what is good or desirable".

This conversation was between a female physiotherapist (late 30s) and a female patient (early 40s) from Nepal. Both communicate with each other using Hindi and a little bit of English. The patient had shoulder pain. The patient had attended the hospital with her husband. During the time of treatment, the husband was waiting outside the cabin.

**PTM9: dard Kaise hain?**

**P13: dard nahi jane?**

**PTM9: nahi jane? aap gar mein koi heavy kam karthi hain?**

**PT14: hmm... Gar mein cooking and cleaning tarah samanya kam Karthi hae**

**PMT10: hmm..... apo, app kaise tharah equipment use kitchen to grind the saman ? Electrical aur manual tharah traditional grinding equipment?**

**P13: maim using purane tharah manual grinding equipment**

**PTM9: heavy rock tharah**

**P13: ji ha**

**PTM9: oh... that is a heavy work... rock tarah old manual grinding equipment ka upayok. Daily Aap use ye tharah quipment haim?**

**P13: Ji ha**

**PTM9: May be Ye hae the aap ki dardh ka karan...at lease kuch dhin aap better to cook simple curry like chapathy and subji curry. Aap lok banana north Indian subjicurry , Hai na? Using subjis without grinding.**

**P13: (nod her head like yes) App mehra husband keliye kahthe henha? (smile) Bhojan kae sath haar dhin voh pasath the grinding curry.**

**PTM9: Do not worry.thumara husband ko mehm pura thing bholthi hoom ham?**

**P13: (nod her head like yes) smile**

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**PTM9: How is your pain?**

**P13: Pain is not reduced**

**PTM9: Is not reduced? Did you do any heavy work using this hand?**

**P13: Hmm..... I usually do the household jobs like cooking and cleaning**

**PTM9: Hmmm... then what kind of appliance you usually used to grind the ingredients at the kitchen? Is it electric mixer grinder or any other traditional manual grinding equipment?**

**P13: I am using the old kind of manual grinding equipment**

**PTM9: The one with the heavy rock. Isn't it?**

**P13: Yes**

**PTM9: Oh... that is a heavy work... using the rock type old manual grinding equipment. Are you using it daily?**

**P13: Yes**

**PTM9: That's may be a reason for not reducing the pain ... At least for a few weeks better to do some simple cooking like chapathy and**

**subji curry. You people make subji curry isn't it? Using vegetables without grinding.**

**P13: (Nod her head like yes)... can you tell this to my husband as well? (Smile). He likes to have the grinding curry every day.**

**PTM9: Do not worry. I will explain all the things to your husband. OK?**

**P13: (nod her head like yes) smile...**

The therapist has initiated this conversation by using an interrogative mode to evaluate the patient recovery ('*How is your pain*'). This is considered as a usual process in the medical conversation. Here, the therapist put forward a patient centred approach by knowing the patient opinion about his recovery. So, a mutual power relationship can identify in this part of the conversation. The patient answer was identified as the expression of his concerns about the recovery in the form of worries; this can see in the line '*Pain is not reduced*'

Then, without receiving any direct hint from the patient the therapist made a propositional act of assumption regarding the grinding equipment (Fairclough, 2003). The propositional act of assumption is the assumption is about 'what is or can be or will be the cause' (Fairclough, 2003). This can see in the line '*what kind of appliance you usually....*'. The therapist's assumption was clearly related to patient's role as a housewife. The patient's answer at that time '*I am using the old kind of manual grinding equipment*' was considered as the next level of contribution to this conversation. Here, the way of patient's response was not only an illustration of understanding the question asked by the therapist but also a form of acceptance of the texts assumption (Fairclough, 2003). The following response of the therapist '*The one with the heavy rock. Isn't it*' was an evidence of the therapist's detailed knowledge about the domestic situation of the patient. Then, the patient had again accepted the therapist assumption by giving a confirmation to the therapist's question ('yes'). So in this way, a mutual sharing

of knowledge occurred between both parties (patient and therapist). In this conversation, the patient accepted different kinds of assumptions from the therapist's side. This illustrated how both parties attempted moment-by-moment to reduce their differences through finding common grounds (Fairclough, 2003). As a result, the common ground becomes the outcome of this conversation.

In this above interaction, it can be identified that the female therapist had done a professional way of clinical reasoning by knowing the social situation of the patient. Many of the clinical tasks including clinical reasoning required an understanding of the person as well as the disease (Edward et al., 2004). In several situations for conducting an effective clinical reasoning there arose the necessity to incorporate therapist's non-biomedical knowledge. The quote below is an example of how the therapist incorporated his non-biomedical knowledge in the medical context.

*'When I was a child I had lived in a village in a hilly area and got the opportunity to mingle with the local people. So I know their lifestyle and all. So that experience helped me to understand the people came from those kinds of society and helped me to handle their conditions better and also help me to make a better rapport with them'(PTR6).*

This quote was taken from the informal conversation with PTR6 in the first stage of data collection. The quote revealed that the non-biomedical knowledge that the therapist obtained outside of the academic curriculum used in his professional practice to enhance the patient outcome in different ways.

In extract 8, knowledge about the socio-cultural context of the patient was effectively enhanced the clinical reasoning. 'The common grounds identification' in this extract could be considered as a speech technique that helped the therapist to collect the useful information from the patient to recognise the reason

behind her not getting better. This can be identified as the therapist's professional skill to communicate effectively to create a better relationship to identify the patient's issues related to the symptom. So, in this conversation, the clinical reasoning becomes an interactive and patient centred process rather than a cognitive clinician centred process.

Active participation and shared power and responsibility between patient and therapist can be identified in this extract to enhance a clinical reasoning (*'Is not reduced..... That's may be a reason for not reducing the pain'*). Therefore, a mutual power relation between patient and therapist can be found in this conversation

In terms of the power relationship, it is essential to consider the age and gender elements associated with patient and therapist. Here, the patient and therapist are same age group and gender. Earlier, the power balance between the similar age group of patient and therapist were discussed in extract one. How the power balance enabled them to create a better therapeutic relationship with their own age group were also discussed previously. In this extract 8, it was considered that not only the age group but also the same gender of patient and therapist helped to create a common ground between them.

*'I feel keep better bond with patients whom I can share the jokes, that is with female patients in 40s'. (PTM9)*

PTM9 mentioned that sharing jokes was a means of creating the rapport and she considered it was only possible with similar age group female patients. That is, the same gender and age group of both parties could be enable them to find common grounds in an easy way and thereby build the rapport. According to Holmes (2000), humour is an indicator of friendliness and as an expression to

strengthen the solidarity. So, this in turn, helped to enhance the therapeutic interpersonal relationship. In extract 8 it is considered that the female identity of the therapist helped to recognise the social situations of the patient in a quicker and effective manner. Because in Indian social context females are considered to be responsible for cooking and household jobs. So, this kind of reorganisation from the therapist's side seems to reduce the social distance between the patient and therapist. Also, it identified as to create a better rapport between patient and therapist with same age group and gender through finding common ground.

Here, the clinical reasoning was conducted by assuming common grounds that encouraged the patient to become more open as well (*'can you tell this to my husband as well?'*). The openness from the patient's side was considered as an example of the developed positive therapeutic relationship. From this aspect, it can be identified that the clinical reasoning using common grounds was used to support a positive therapeutic relationship. The patient was also a north Indian, so knowing the culture of the patient was also an important matter in the therapeutic process. While interacting with the patient, the cultural knowledge of the therapist was enabled her to provide sufficient advice on patient's daily activities (*'simple cooking like chapathy and subji curry. You people make subji curry isn't it?'*).

An empathetic approach from the therapist's side can be found in the line *'oh... that is a heavy...'* Also, here, the therapist detailed knowledge about the equipment (*'that is a heavy'*) could be helped her to realise the patient's non-reducing pain. That is the non-medical knowledge of the therapist about the patient social situation could be utilized to demonstrate her personal (empathetic) as well as the professional (clinical reasoning) manners to the patient in an appropriate way. Previously, chapter two discussed the professional and

personal manners of the therapist and how its influence on creating better therapeutic relationship.

### **Extract: 9**

The pattern of the conversation in extract 9 is similar to extract 8. This is another conversation of PTM9 (who involved in extract 8) with a different patient P12, a young female patient in her early 40s.

***PTM9: Ennu angane undu?***

***P12: Shoulder il epozhum vedana undu***

***PTM9: Ee Kai vechu special ayttu Enthengilum Joli cheytho? Cookingo Cleaningo?***

***P12: Aha, ennalae cooking orupadu chaythayrunnu.***

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***PTM9: How you feel today?***

***P12: Pain is still there in the shoulder***

***PTM9: Did you do anything special job with this hand? Cooking or Cleaning?***

***P12: aha, I did a lot of cooking yesterday.***

In this extract, the therapist did a propositional act of assumption (*'Did you do anything special job with this hand? Cooking or Cleaning?'*) and it seems to address the patient concerns (*'Pain is still there in the shoulder'*). Here, the non-medical knowledge of the therapist about the patient social situation contribute a major role in producing a propositional act of assumption from the therapist's side. The patient accepted the therapist's propositional act of assumption. So that illustrated the distance between the therapist and the patient reduced and they find common ground each other through sharing the knowledge. Reduction in social distance helps to create a trust between either parties (Loignon et al., 2015). This, in turn, helps to develop the better relationship.



## **7:2:2 Non-medical related shared narrative**

Extract 10, 11 and 12 are the examples of the sub theme non-medical related shared narrative in which the therapist encouraged the patient to share their reveal something about their identity and a life outside the hospital.

### **Extract: 10**

This conversation is an example of how the patient and therapist share commonalities with each other during their interactions and use them to build up their rapport. Here, both the therapist and the patient were from the same religious community (Hindu) and they share their mutual religious belief as the element to build up a positive relationship. The conversation was between a male therapist in his late 30s (PTS10) and a male patient in his early 40s (P14).

*PTS10: Epo angane undu?*

*P14: Epoozhum stiff anu, pakshe nerathekailh kuravundu*

*P14 (in long sitting position on a couch)*

*PTS10: kidano (patient lay on his back, therapist starts palpating, then apply some mobilization technique)*

*Ambalathil poyo?*

*P14: poy sir*

*PTS10 athambalathilanu poyathu?*

*P14: Sreekandeswaram. Aa ambalathil ullathu Bhayangara shakthi ulla daiva. Anntae asugham maranokae orupadu sahadichittundu. Sirinu ariyamo Aa ambalam.*

*PTS10: hmm. Anikariyam. Anikku Murugane anu bhayangara ishtam. Sreekandeswarathu shivan allae?*

*P14: athe sir, Yatharthhathill nammal randuperum oru familiyil thanna vishwasikkunnathu(smile)*

*Ethethu technique anu. Ethu nalla rasamundu and kuduthal effect ullapole thonnanu.*

*PTS10: (close both eyes and smile at me). Ethu nammude traditional kalu thirumalu polthe technique anu. Ethu nongalude blood circulation improve akkum.*

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*PTS10: how is it now?*

*P14: still stiff, but reduce than before.*

*(P14 in long sitting position on a couch)*

*PTS10: lay down (patient lay on his back, therapist starts palpating, then apply some mobilization technique)*

*PTS10: Did (you) go to the temple? (there was found a religious sign in patient forehead)*

*P14: went, sir*

*PTS10: which temple you went?*

**P14: Sreekandeswaram. The God in that temple is very strong. He helped me a lot to recover.**

**Sir do you know that temple**

**PTS10: hmm. I know.**

**PTS10: I like Murugan very much...Sivan is at Sreekandeswaram, isn't it?**

**P14: yes, Sir**

**PTS10: So actually we both believe in the same family (smile)**

**P14: smile.**

**P14: What this technique is. This is feeling good and feel like more effective.**

**PTS10: (close both eyes and smile at researcher). This technique is similar to traditional leg massage. This increase your leg blood circulation**

As mentioned above the therapist initially encouraged the patient to share the narrative by asking different questions (*'Did (you) go to the temple which temple you went?'*) and found the common ground.

In this extract, the therapist used a propositional act of assumption by asking the question regarding the visit of the temple (*'Did (you) go to the temple'*). From this point onwards the conversation turns to find common grounds. Throughout the conversation, both parties accepted the assumptions that each other had about their interpretations of the other party's utterances (eg: 'hmm... I know', 'yes.'). These types of responses may be considered excellent attempt of finding common grounds with each other.

During the conversation, the patient illustrated his strong belief in God (*'The God in that temple is very strong. He helped me a lot to recover'*). The patient did an attempt to maintain the common ground by mentioning that even if both the therapist and patient followed different Gods the familial origin of them was the same (*'So actually we both believes in the same family'*). Even though the conversation was related to a non- medical narrative the line *'He helped me a lot to recover'* illustrate that the patient relates the topic to his health. This could be considered as an evidence that how the non-medical and medical belief linked together.

Here, in this conversation, the therapist disclosed his religious belief (*'I like Murugan very much...'*). In professional relationships, people are not expected to reveal the personal self. However, health professionals may disclose something about themselves (the personal matters) to their patients as a part of creating the better bond. According to Lussier and Richard (2007) before deciding whether to reveal something about themselves, health professionals must know their patients well. Otherwise, there is a possibility to interpret the therapist's action incorrectly by the patient. In this extract, therapist disclosed himself after identified the patient as a believer of Hindu god (*'here was found a religious sign in patient forehead'*) and confirm it by asking about the visit to the temple *'went to the temple?'* In the literature, there is discussion around the advantages and disadvantages of self-disclosure in professional relationships (Lussier & Richard, 2007). According to Lussier and Richard (2007), the main advantage of self-disclosure is the creation of a greater sense of closeness, greater empathy and a climate of trust. This, in turn, helps to create a better bond with the patient. The possibility of physicians crossing the boundary that separates their personal and professional roles is identified as the main disadvantage of self-disclosure (Lussier & Richard, 2007). But, in this case, it is clearly identified that self-disclosure was helpful in forming the better bond with the patient.

*'I felt some patients have shown a special proximity if they identify we are of their same religion' (PTS10).*

In the above quote, PTS10 expressed his experience about how certain patients respond when they identify the therapist shared the same religion. As PTS10 expressed in this quote, the therapist's act of disclosing religious matters or encouraged the patient to make a narrative on religious aspects in extract 10

could be based on the therapist's previous positive experience that he received from the patients.

During the time of the interview, many therapists shared their experiences on how religious matters influence the patient-therapist relationship. So, the next section is a discussion on the role of religious related matter involved in the conversations on solidarity.

*'For example, if we used the term 'umma' while we explained to a Muslim bystander about their mother's disease condition, they seem to be happier with that usage or they are comfortable with that usage.'* (PTR17)

*'The people from Hindu religion address the elders Acha/Amma, they are one group, Christians address the elders like Appacha/ Ammachi, is another group. Some other group also there. Once, I had addressed a patient from Christian community like Acha, then they back answered me that he was not Acha because Amma or Acha is not a word to address elderly people from their religion'.* (PTP19)

*'When I worked in Alapy that area was a Christian area. So everybody address elders Appacha or Ammachi. Even I am a Christian I am not used to addresses elders Appach or Ammachi. I am born and brought up in Thiruvanathapuram. So, I usually address elders like Amma or Acha. So when I worked at Alapy for making better bond I changed the addressing word'* (PTR17)

The above quotes illustrated the importance of knowing the patient's religious background and how to address the people according to their religion in Indian culture. So, addressing the elderly patient from a different religion on the basis of their religious belief is not only considered as the way of demonstrating the respect but also it is a way of expressing solidarity to them (Salifu, 2010). This, in turn, is recognised to enhance the therapeutic relationship (Salifu, 2010). Awareness of the reactions from the patient's side while addressing them will allow therapists to respond to them so that they can attend appropriately to their patient's interaction.

A mutual power relation between patient and therapist can be identified throughout extract 10. In extracts 7, 8, 9 and 10 the patients and therapists were in their similar age group and their gender was also same. This is essential to take into consideration. The quote below illustrates the perspective of a young male physiotherapist about the role of the patient's age and gender influence him in the daily clinical practice.

*'Young age male patients are easy to handle' (PTR7).*

According to PTR7 both the age and gender of the patient had a significant role in handle the patients. The equal power that the therapist experienced while handling with the patients in their gender and age group may be the reason behind the perspective of PTR7. So, in terms of solidarity, these evidences (extract 7, 8, 9 and 10 and the perspective of PTR7) illustrate that while interacting with the patients in their similar age group and gender the therapist had been using solidarity as an approach to create the better therapeutic relationship. This attempt may or may not be a conscious effort from therapist side.

### **Extract 11 and 12**

The structure and function of the conversation in both extract 11 and 12 is the same and is considered as the clear illustration of shared narrative. Extract 11 and 12 comprises of PTO4's, a female young intern therapist conversation with two different patients. Both of the patients involved in these conversations and the therapist were in their same age group and the same gender.

**Extract: 11**

**PTO4: Evideya sthalam?**

**P5 : Lakshadeep**

**PTO4: Apo evide treatmentinu vendi vannathano?**

**P5: Athe**

**PTO4: Malayalam angane padichu**

**P5: Sister-in law padipichu**

**PT4: Keralithil ninano**

**P5: athe**

**PTO4: Lekshadeepil evideyanu?**

**P5: Minicoy**

**PTO4: Njngalku Minicoy il ninnu oru patient undayrunnu**

**P5: Ah evude? (Very happy)**

**PTO4: athe treatmentinu vendi vannathu... Anta actually sambavichathu. Vennathano atho stpil ninnu slip ayo.**

**P5: Ethu niskarathinte samaythu ptiyathanu. Niskaram kazhinju ezhunettapol peetunu kalu madangi poy**

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**PTO4: Where is you place?**

**P5: Lakshadweep**

**PTO4: Then you came here for treatment?**

**P5: Yes.**

**PTO4: How you learn Malayalam?**

**P5: Sister-in law teach**

**PTO4: Is (she) from Kerala?**

**P5: Yes**

**PTO4: Where you exactly in Lakshadweep?**

**P5: Minicoy**

## Extract 12

**PTO:** *Ethu standardil anu padikkunnatu?*

**P6:** *second year B.com*

**PTO4:** *Ethu College?*

**P6:** *Theresa*

**PTO4:** *Evide ya?*

**P6:** *St Theresa.*

**PTO4:** *Oh Theresa's*

**P6:** *ah...*

**PTO4:** *Ennu ningalude college off ayrunno?*

**P6:** *ah... ennu lectures oru strike enu pokum*

**P6:** *Peru entha?*

**PTO4:** *xxx*

**P6:** *Enthu (parichitham allathae peru pole)*

**PTO4:** *pathuke perinte spelling paranju.*

**P6:** *oh... epo enikku manazilay (chirikkunnu). Evidunna?*

**PTO4:** *Than, Njan vere evidennenkilum annenu vicharicho (Vidhesathu ninnulathano ennanu udhesichathu)*

**P6:** *Athe (smile)*

**PTO4:** *Trissur*

**PTO4:** *Njan ultrasound cheyyumbol pain thonnunundo*

**P6:** *hmm ... (purikam chulikkunnu pain ullathu pole) pakshe severe alla.*

---

**PTO4:** *Which standard (you) are studying?*

**P6:** *Second year B.com*

**PTO4:** *which college?*

**P6:** *Theresa*

**PTO4:** *Where?*

**P6:** *St Theresa.*

**PTO4:** *Oh Theresa's*

**P6:** *Ah...*

**PTO4:** *Is your college off today?*

**P6:** *Ah,our lectures go for a strike today*

**P6:** *What is your name?*

**PTO4:** *xxx*

**P6:** *What? (Like a strange name)*

**PTO4:** *Spell her name slowly*

**P6:** *Oh... now got it (smile) Where (you) from?*

**PTO4:** *Did you think I am from somewhere else (in the sense foreigner)*

**P6:** *Yes (smile)*

**PTO4:** *Trissur*

**PTO4:** *Do (you) have pain when I doing the ultrasound*

**P6:** *Hmm ... (frowning her eye brow like pain is feeling) but not severe.*

**PTO4:** *We had a patient from Minicoy*

**P5:** *ah... Here? (Very happy)*

**PTO4:** *Yes, came for the treatment... What actually happened? Did you Fall? Or slipped from step?*

***P5: This will happened during the time of niskaram (Muslim prayer). After the prayer I got a sudden bending on my leg.***

Both of these conversations happened during the time of treatment session. In both of the above conversations it is clear that the therapist had taken an initiative to encourage the patient to reveal something about their identity and a life outside the hospital (extract 11: *'Where is your place?'* extract 12: *'Which standard you are studying?'*). It could be considered as an approach from therapist side to build a rapport in their relationship.

The patient in extract 12 took this as an opportunity to initiate turns in the conversation (Heritage & Clayman, 2011). As explained in chapter 3 turn taking is an element of conversational analysis theory and it illustrates "when and how people take turns in conversation." (Fitch & Sander, 2004). Here, the patient's attempts in turn taking created a shift in the interaction. That is the interaction shifted from a clear asymmetrical power relation to the level of equals in the conversation (Defibaugh, 2014). In the initial section of the conversation in extract 12, it can be identified a question- answer pattern between patient and therapist, in which patient had answered all the question asked by the therapist. It is apparent from the line *'Which standard (you) are studying?'* to *'ah, our lectures go for a strike today'*. A power of asymmetry can be visible in this section. But later on from the line *'what is your name?'* onwards the patient took active turns in asking questions and the conversation attains the level of equality.



In these conversations (extract 11 and 12) it is essential to consider the patient's socio-cultural background. Both the patient and the therapist in extract 12 were from Kerala that means both were coming from the same socio-cultural background in its wider aspect. However, the patient in extract 11 was from Lakshadweep, possessed a different socio-cultural background from that of the therapist had. Even if both parties communicate in the Malayalam language, the patient in extract 11 was not fluent in Malayalam. The different cultural background from that of the therapist and issues in language fluency could be considered as the reason behind the less active role taken by the patient in extract 11.

It is apparent that in extract 11 all the conversation topic was introduced by the therapist (however, sometimes patient's word was used for making questions; for instance '*Where you exactly in Lakshadweep?*'). Patient responses was mainly identified as in the form of answer to the therapist's question. The therapist could be asked all those informal questions to encourage the patient to reveal something about their identity and a life outside the hospital. Even if the patient had responded to all of the therapist's questions, certain responses from patient side could be considered as an evidence of backchannel responses (yes, ah). Individuals who do not want to take turns may be use these kind backchannel responses in their conversation (Levinson & Torreira, 2015).

This evidence illustrated that even the therapist and patient were in their similar age group and the same gender. However, the culture and language may be become a barrier to make the patient active in this situation. This identification is contradictory to what has seen in extract 8. That is in extract 8, it is recognised that the female therapist and patient in their similar age group and from different cultures were shared their power equally and created a better bond together. Both

of the patients in extract 11 and 12 met PTO4 in their first time. However, the conversation between patient and therapist in extra 8 was not their first conversation session. So, possibly these evidences point out that time is a relevant factor in creating therapeutic bond. Or it can be explained that even if the patient and therapist from different cultural background their relationship possibly becomes better over-time.

Even though the therapist and the patient in extract 11 were from the different socio-cultural background still the evidence to create the common background is visible in their conversations. For instance, the line '*We had a patient from Minicoy*' can be considered as an example from the therapist's side to illustrate a common ground with the patient.

In both of these conversations it can identify that after a short section of non-medical talk the therapist took turn taking to medical talk (extract 11: '*What actually happened?*' and in extract 12: '*Do you have pain when I doing the ultrasound*'). This could be illustrated that the therapist control over the conversation without losing her objective as a therapist.

### **7:3 Synthesis of the results**

Table 7: 1 illustrated the synthesis of relevant findings identified in each stage of data analysis associated conversations on solidarity and its influence on the therapeutic relationship.

The therapist revealed the solidarity by expressing their alignment with the patient by encouraging the patient to share narratives. Based on the content of

**Table 7:1 synthesis of findings of chapter 7**

Subtheme	Textual	Interpretive	Explanatory
Medical related shared narrative	Illustrating Alignment each other  Openness from patient side  Propositional act of assumption from therapist's side  Finding common grounds	Encourage patient's autonomy  Rapport  Therapist critiqued the opposing ideological belief of what the patient belief.  Patient's trust in therapist  Diplomatic attitude from therapist's side  Therapist's Attitude about Ayurvedic medicine  Clinical reasoning in patient centred way	Similar Age and gender  Mutuality.
Non-medical related shared narrative	Propositional act of assumption from therapist's side  Finding common ground  Self- disclosure  Turn taking from patient side  Alignments	Rapport  Time	Mutuality  Similar age and gender  Religious matters

the narrative two different types of narrative identified as subtheme; medical related shared narrative and non- medical related shared narrative. Showing alignment each other, finding common grounds each other and propositional act of assumption from therapist's side was recognised as the common interactional features used to build the solidarity and therapeutic relationship in the situations created in both of the subthemes. In medical discussions, the patients illustrated

openness and in non-medical narratives, the therapist illustrated self-disclosure and the patient's turn taking could be considered to illustrate their active participation. These in, turn, identified as the essential element to create the positive therapeutic relationship.

For demonstrating the solidarity the therapist also critiqued the opposing ideological belief of what the patient belief. Also, encourage patient autonomy, patient's trust in therapist, therapist's self-disclosure, clinical reasoning in a patient centred way, therapist diplomatic attitude, rapport creation and therapist's attitude towards Ayurvedham are all interpreted as the institutional contextual factors that enhanced the solidarity and therapeutic encounter. Equal power relations (mutuality) are identified in all the extracts associated with solidarity and is considered as an important element to create a better therapeutic relationship. One of the interesting factors find in these solidarity forming conversations are the patients and therapists involved in these conversations were in their same age group and gender. This, in turn, identified to help in reduce power between both parties in their conversation. So, it is considered that age and gender related power as a factor in expressing solidarity to improve the therapeutic relationship. Religious matters also identified as a factor that could be used to reduce power between patient and therapist in their relationship in certain situations.

#### **7:4 Chapter summary**

This chapter explained the textual features, contextual elements, and the power relationships related to solidarity conversations between therapist and patient, which helped to create the better therapeutic relationship in Indian physiotherapy settings. As described in the synthesis section this chapter

analysed specific linguistic features, that were used to express the solidarity; identified certain socio-cultural elements involved in solidarity talk; the underlying power relationship of the speakers and described how these findings linked with therapeutic relationship.

## **Chapter 8: Expectation and Therapeutic Relationship**

### **8:1. Chapter introduction**

This chapter describes the interactional features, the contextual factors and the power relationship in the matter of patient expectations and how it is associated with the therapeutic relationship in the Indian outpatient physiotherapeutic settings. The chapter is comprised of a subtheme; that is 'incongruence between patient and therapist'. Three sample extracts from the audio recorded interactions of patient-therapist were selected to describe this subtheme. The extracts consisted of conversations related to patient expectation, which happened during the time of treatment sessions. The therapist and the patient perspectives that were obtained from their interviews were also used as the supportive resource to interpret the extracts. This chapter comprises of an introduction about the theme patient expectation and the role of patient

expectations in creating the therapeutic relationship analysis of the selected extract, synthesis of the result and a summary at the end.

## **8:2. patient expectation and the therapeutic relationship**

Patient expectation is increasingly seen as an important area in health care research because it has been used to explain the different aspects of the clinical process, including patient compliance, patient satisfaction, outcomes research, and the physician-patient relationship. This chapter mainly focused on how patient expectation are associated with the therapeutic relationship.

Previous research identified that expectations that a patient brings to treatment have important influences on the therapeutic relationship (McCrum et al., 2016). So, it is necessary that the physiotherapists have a better understanding of patient expectations about physiotherapy treatment. The patient expectations are influenced by a number of factors, including patient's previous experiences, present condition, socio-cultural background, patient belief and personality (Barron, Moffett & Potter, 2007). The therapist's failure to recognise the patient expectation can possibly lead to incongruence between the therapist and patient (Payton, Nelson & Hobbs, 1998). This kind of incongruence between therapist expectations or perceptions may influence the patient-therapist encounter. To some extent, it is due to lack of effective communication that was performed during the time of patient-therapist consultation session (Payton, Nelson & Hobbs, 1998). This kind of in-effective communication negatively affects patient and therapist relationship. Because evidence identified that effective communication is the foundation of creating good quality therapeutic relationships (May, 2001; Hush, 2011). Previous literature in different disciplines, including general medicine, nursing, occupational therapy and physiotherapy,

points out the importance of patient centered approach to minimise the potential problems associated with miscommunication and address the issues related to patient expectation (Gerteis, Levitan, Daley & Delbanco, 1993; Mondloch, Cole & Frank 1999; Potter, Gorden & Hamer, 2003). Previous literature in physiotherapy context identified that use of the patient –reported outcome measure is an effective way to identify patient expectation (Kyte et al., 2015). According to Holmes et al. (2017), the patient-reported outcome measure helps to capture patient's own opinions on the impact of their condition, and its treatment on their life from each phase of the therapeutic process. Kyte et al. (2015) found that the patient-reported outcome measure enhances the patient-therapist communication and ensures the active engagement of the patient in the therapeutic process. So, the introduction of a patient-reported outcome measure considered always support patient centred care and helps to prevent the incongruence between the therapist and patient expectation (Kyte et al., 2015; Holmes et al., 2017). This, in turn, helped to improve the patient-therapeutic encounter.

Previously in chapter one it is mentioned that many of the developing countries adopted the principles of patient-centred care in physiotherapy practice. However, it is argued that not all patients prefer to be cared for on the basis of patient centred care model (Pluut, 2016). Patient's socio- cultural background have an influence on patient's preference on this (Rademakers, Delnoij, Nijman, & De Boer, 2012). Rademakers, Delnoij, Nijman, & De Boer, (2012) study found that patient's social class, age, education level, gender, and ethnicity have been shown to influence the patient's choice of treatment approach like patient centred approach. For instance, Beisecker (1988) and Sullivan and Mittman (2010) suggests that older patients may prefer or be more satisfied with a less patient-

centered medical encounter. In contrast, Peck (2011) found that patient satisfaction was higher among elderly patients in patient-centered encounters. The study of Rademakers, Delnoij, Nijman, & De Boer, (2012) identified that majority of highly educated patients prefer a patient-centred communication style and less educated patients are more likely to prefer a directive, biomedical approach. In this kind of situation, it is essential to think beyond a patient centred care to satisfy the patient. Timothy (2016) suggest a patient-perspective care could be a choice of treatment approach in this type of situation. Explanation regarding the choice of patient treatment strategy in chapter one maybe an example of this. That is even if the basic principle of the physiotherapy treatment is to make the patient active in rehabilitation, provide the treatment to the patient based on what they prefer (active or passive). According to Timothy (2016), patient-perspective care is based on the fact that help can only ever be defined by the helpee rather than the helper. However, the concept of patient-perspective care not been widely discussed yet in the field of health care.

Patient expectations have been recognized as a factor for patient satisfaction in medical consultations (Potter, Gorder & Hamer, 2003; Berhane & Enquesselassie, 2016). Hills and Kitchen's (2007a) study found that patients with chronic conditions (PCMC) tended to have higher expectations and lower satisfaction with treatment. However, the study identified the patient with acute musculoskeletal condition (PAMC) tend to have lower expectation and high satisfaction with their treatment outcome. According to Hills and Kitchen (2007a), the unformed expectation about the physiotherapy experience to be made the PAMC optimistic about their treatment outcome. However, the PCMC'S higher expectations about change (recovery) often found as the reason behind their less satisfaction (Hills & Kitchen, 2007a). So, in such cases meeting patients'



expectations considered as a way to improve patient satisfaction, which is strongly associated with therapeutic relationship (Hall et al., 2010; Hush, 2011; Hills & Kitchen, 2007a).

Payton, Nelson, and Hobbs (1998) interviewed 109 patients from three health care facilities about their relationship with health care professionals. They found that almost half the respondents were unclear about what physiotherapy was, with 46% having no expectations of their own role and 40% no expectations of the therapist's role in their care. Therefore, this study pointed that patients are unfamiliar with physiotherapy do not know what to expect. However, Hills and Sheila (2007b) argued that patients do have expectations of physiotherapy even if they do not have any previous experience about physiotherapy. Such kind of expectation may be tentative. Patients participated in this interview also expressed such kind of expectations. For instance, '*I thought in physiotherapy we got an oil massage kind of treatment*' (P22).

The therapist should identify these kind of patient's expectations and educate the patient about what is physiotherapy before referring them to the physiotherapy treatment. Also, assist the patient to form achievable expectations and goals at the start of their treatment program. So, satisfaction with the therapeutic experience could be enhanced by directing treatment input toward meeting these informed expectations.

A number of studies included in chapter 2 related to both therapist and patient perception papers implied that expectations might influence the therapeutic relationship (Potter, Gordon & Hamer, 2003; Hills & Kitchen, 2007). The studies that analysed quantitatively also found the relationship between patient expectation and therapeutic relationship (Vong et al., 2013; Fuentes et

al., 2014). However, none of the studies in physiotherapy analysed how the interactional features, power sharing as well as the contextual features were associated with patient expectation and how it related therapeutic relationship. Therefore, this chapter will analyse the physiotherapist's way of handling the patient's expectation relate issues and the role of therapeutic patient-therapist relationship in this.

As mentioned in the introduction patient expectation and its association with the therapeutic relationship is explained using two themes: incongruence between patient and therapist and patient expectation about physiotherapy treatment.

### **8: 2: 1. Incongruence between therapist and patient expectation**

This subtheme deals with how the patients expressed their concerns, demands and doubt that was raised as the result of the incongruence between therapist perspective and patient expectation. This particular theme is explained by using extract 13, 14 and 15. The patient in extract 13 expressed the concerns about his recovery and the patient in extract 14 shared his active demand as well as his concerns with the therapist. In extract 15 the patient expected passive kind of treatments from physiotherapy. However, without proper identification of the patient expectation the patient was given an active physiotherapy treatment by the therapist. So, in this situation, the patient expressed the expectation in the form of doubt. Therefore, the extract 13, 14 and 15 discuss how the incongruence between patient and therapist influence to create a better therapeutic relationship.

#### **Extract 13**

This interaction is an example of how the patient's concern about his recovery, which raised as the result of the incongruence between therapist perspective and patient expectation, influence on the therapeutic relationship. The extract was taken from the outpatient physiotherapy department of the public sector and the conversation was between a young male therapist (30s) and an old male patient (60s). The patient had been referred to the physiotherapy department for post-surgical stiffness of his hand.

***PTR7: Entengilum improvement thonnundo?***

***P20: Enikku oru improvementum thonnunila.***

***Eniiku Epozum pazhayathupole thanna annu thonnunnu.***

***PTR7: Njan onnu nokkatae (Patientinteanterior forearm muscle palpate cheyyunnu). Nokku ee bhagathe tightness kuranjittudu, Illae?***

***P20: Hmm***

***PTR7: Epo ea area loose ayttundu. ...nerathe cheytha treatment vachittu Ethayruunnu njan aim chaythathu... OK?***

***P20: Ah... Loose***

***PTR7: Haa...***

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***PTR7: Do (you) feel any improvement?***

***P20: I do not feel any improvement. I think it's still the same***

***PTR7: Let me have a look (Palpated the areas of his anterior forearm muscle).....See the tightness of this area reduced. Isn't it?***

***P20: Hmm***

***PTR7: Now the area becomes loose....based on the previous treatment this is what I aimed ... Ok***

***P20: Ah. Loose...***

***PTR7: Haa....***

The therapist has initiated this conversation by using an interrogative mode to evaluate the patient recovery ('Do (you) feel any improvement?'). This considered as a usual process in the medical conversation. Here, the therapist sought a patient centred approach by seeking to know the patient's opinion about

his recovery. So, a mutual power relationship can be identified in this part of the conversation. The patient answer was identified as the expression of his concerns about the recovery in the form of worries; this can see in the line '*I do not feel any improvement*' and '*I think it's still the same*'.

The therapist accepted the patient concerns, which is evident in the line starting from '*Let me have a look...*' The followed line (*see the tightness...*) is an example of the therapist's act of convincing to the patient in terms of recovery. However, the patient response ('hmm') is identified as a partial acceptance of what the therapist said and is recognised as a possible feeling of dissatisfaction from the patient's side. The line '*Now the area become loose*' can be considered as another attempt from the therapist's side to emphasise the positive outcome to convince the patient; who had not fully accepted the therapist's explanation. Here, in this conversation, the therapist exerts his power as a medical expert. The line '*Now the area become loose. Based on the previous treatment this is what I aimed*' could be an illustration from the therapist's about the 'achieved recovery', which the therapist considered as his expected level of outcome that he achieved from the patient at this stage of recovery. However, the patient's raised concern ('*I do not feel any improvement. I think it's still the same*') and certain replies ('hmm, ah. Loose'), in the form of partial agreement might be considered as an evidence that reveals the patient had a variant expectation from that of the therapist.

A paternalistic approach can be identified in the line starting from '*Based on the previous treatment this is what I aimed*'. Basically, here, the therapist used an assertion. While expressing the assertion the therapist used 'I'. So, this type of assertion can be categorised as an 'I language assertion' (Hargie, 2016). 'I language assertion' can be used to express the assertion either in a negative or

in a positive way (Hargie, 2016). In this context the 'I language assertion' used to illustrate the paternalism. This possibly affects therapeutic relationship negatively.

Because the paternalistic approach found in this extract is different from what we saw in extract 5 (chapter 6). In extract 5 the therapist used the paternalistic power and the power of knowledge to facilitate patient healing. However, here in this context, the therapist used paternalism to show the 'excellence' of his knowledge and skill to the patient and the 'excellence' of the treatment method that had been given to the patient (power of an expert). This possibly affects the therapeutic relationship in a negative way.

But, it can also be considered as an approach of persuasion from therapist side to persuade the patient that recovery is happening (*'Now the area becomes loose....based on the previous treatment this is what I aimed '*). This could be identified as the therapist attempt to reassuring the patient. However, the patient's minimal response (*Ah. Loose...*) in this situation could be indicate a less satisfied patient rather than a reassured patient.

It can be identified that the therapist in extract 13 focused more on patient's condition rather than the patient as an individual. This may be the reason behind the use of I language assertion by the therapist. The studies identified that care became better and patient become satisfied when it recognises what patients individual problems are rather than what the condition is (Mead & Bower, 2000; Starfield, 2011). The therapist can achieve this in a way to recognise the nature of the patient's problem, act accordingly and assesses how the patient's problem change in response to what the therapist did. Here, in this context, the therapist focused the condition based prognosis, which can be considered as the

interpretation of therapist on patient's medical problem. So, 'focus on patients rather than condition' can suggest as a mantra in this context to make the therapists aware about the necessity to consider the patient as an individual while providing treatments.

Introduction of a patient-reported outcome measure (which is described earlier in this chapter) could be an effective method to control or avoid the observed clinician centred approach or paternalistic approach in extract 13. This helped to improve the patient-therapeutic encounter. The below quotes from PTU8 explained how lack of a proper outcome measure in the clinical settings affected him in his daily practice.

*'An outcome measure help to avoid patient's revisit. The physiatrist may not be satisfied with the patient attained range. If we have outcome measures and proper documentation we can give proof to them' (PTR7).*

As mentioned in the literature review chapter, in India patients were referred to physiotherapy by the medical doctors. So, here in this quote, PTR7 described that doctors might re-refer the patient to physiotherapy because of the confusion created in the absence of an outcome measure. This possibly decreases the confidence of patients in the therapist. This can in turn, negatively influence the therapeutic relationship. So an introduction of a patient -reported outcome measure, which considers to capture the patient expectation appropriately before referred the patient by the doctor to physiotherapy treatment would help both the doctor and the therapist to handle the patient expectation easily.

In this analysis, it is essential to consider the therapist's perspective on less satisfied patients. Next section will analysis an example of this. In the below quotes PTA11 and PTS10 explained their perspectives on the aged patient's satisfaction.

*'The old age patients are sometimes a bit hard to handle because they do not agree their pain reduced or they got improvement. Such patients seem they are not satisfied, even if they got better improvement'. (PTA13)*

*'Old age people do not show interest in therapies; they came to us because of doctoral reference. So, sometimes they do not adhere with the treatment. Because of this, they...they do not get any improvement and blame us'. (PT S10)*

According to PTA13 and PTS10, older patients are considered as the least satisfied group. PTS10 recognised the patient's non-compliance with the treatment and related issues were the reason behind the patient being less satisfied. Here, PTS10 and PTA13 were the young aged therapists. So the above quotes could be considered as the perspectives of the young aged therapist about older age patients. Previous literature notes different examples that less advantaged groups (here, it could be considered as the old aged group) effectively resist medical authority through acts of noncompliance, such as missed appointments, refusal to speak the dominant language, and concealing health-related behaviours (Reeves et al., 2010). These patients, usually labelled as non-compliant by the health professional community (Lupton, 1994). The challenges experienced by the therapist because of their failure to recognise the expectation of the older age group patients may be the fact behind this particular perspective of the therapists (PTA13 and PT S10). Also, the reason behind to labelled the older age patient as non-compliant patient by those therapists.

If the therapist is not sufficiently identified the patient's expectation, it will not help the therapist to reach the patient's level of expectation or to satisfy patient in the daily practice. Previously in chapter 6, it was mentioned about the age-related attitude may be considered as a leading cause of non-compliance. Patient attitude is significantly related to patient expectation (Fishbein & Ajzen, 1977). So, in that sense, evidence shows that age-related attitude may be related to the

expectations. So, it is important to identify that how expectations varying with patients age group.

The previous literature in the medical field has identified that age as the factor that influences patient expectation and it in turn related to their preference of medical encounter (DeVoe, Wallace & Fryer, 2009; Noll et al., 2014). Discussion around this topic was included previously in section 8.2. This section describes how patient-centered encounters influence the satisfaction of patients in different age group (Beisecker, 1988; Sullivan & Mittman, 2010; Peck, 2011). From those evidence it can be considered that age of the patient as an element, which possibly influences patient expectations and satisfaction. This, in turn, might be determined the nature of the therapeutic relationship they prefer.

Listening to the patients' stories to learn patients' current experiences and the perspectives associated with those experiences is helped the therapist communicate accordingly and share their power with the patient (Timothy, 2016). Sharing power is significant to adopt a mutual therapeutic relationship and provide treatment according to the patient expectation.

**Extract: 14**

The function and structure of the conversation in extract 14 is almost similar to the interactions found in extract 13. This particular conversation describes how the therapist handles the patient's demand in the clinical setting and how it related to patient expectation and therapeutic relationship. This conversation was between a young female therapist (in her 30s) and an old male patient (in his 60s). The patient came with shoulder muscle complaints.



**PTM9: Epo angane undu?**

**P16: Ydharthathil ennikku kuravuundennu parayyan pattilla athennu vechal anikku epozhu thalathorthan pattunnilla. Pine epozum pallu theykkan bhudhimuttundu.. Ethokae prashnamoke epozhum undu.**

**PTM9: OK. Anthokeyanu epo cheyyan pattathathu?**

**P16: Anikku pandathepole palluthekkkan, thalacheekan, thalathorthan pattunnilla**

**PTM9: Adyathe avastha vechunokkumbol epo kurachengilum kuravu thonunundo**

**P16: athe**

**PTM9: Epo oru 20 shathamam mathrame improve cheythittullu. Athoru chriya shathamam anu. Oru 50 shathamam ankilum improve akumbol ningalkku improve aytta undennu thonnum. OK?**

**P16: Ahh..**

---

***PTM9: How you feel now?***

***P16: Actually I can't say I got reduced (condition) because I can't dry my hairs... Then, still, I have difficulty during brushing teeth. These problems still there.***

***PTM9: OK. What are the activities (you) can't do now?***

***P16: I can't brushing, combing hair, drying hair like before***

***PTM9: If you think right from the initial stage, did (you) feel you got at least a bit of reduced (condition) now?***

***P16: yes***

***PTM9: You got only 20 percentage improvement now. That is a small percentage. If you got at least 50% improvement, then you will feel like you got improved. OK?***

***P16: Ahh...***

Here, the therapist asked the question to the patient with a possible intention to evaluate the patient recovery through a patient centred approach. In this extract, the patient not only expressed concern [*actually I can't say I got reduced (condition)*] but also illustrated the active demands (*I can't...*). The patient expressed the concerns in the form of worries [*actually I can't say I got reduced (condition)*] and the active demands in the form of priorities to improve certain functional activities in his daily life (*I couldn't dry my hairs... Then, still I have difficulty during brushing teeth*). This kind of patient's concerns and demands possibly formed as a result of insufficient realization from the therapist's side about the expectation of patient. The patient has expected a functional based rehabilitation; it can be identified from the line (*Actually I can't say I got reduced*

(*condition*) because I can't dry my hairs...'). So, here, the patient may be expecting his recovery as to perform the activities that he could do before the occurrence of his present shoulder complaint. However, the therapist just expected the patient to have improved as to be better than the worse stage of his condition. Therefore, an incongruence between the therapist and patient perceptive in the case of the expected recovery can identify in this situation. This could be negatively influenced the therapeutic relation (Chang, Park & Kim, 2013).

Here, in this extract, the therapist paid attention to the patient concerns with an interest in the form of reflexive listening [*OK. What are the activities (you) can't do now?*]. Reflective listening is a communication strategy that the listener uses to confirm that the idea has been understood by repeating the same word, phrase or paraphrase used by the speaker (Chang, Park & Kim, 2013). Compared to extract 13 in this chapter, the therapist took effort to convince the patients. The therapist may be asked this question '*If you think right from the initial stage*' with the intention to persuade the patient about the recovery that had been achieved. Also, educate the patient about his gradual recovery using declarative modes in the conversation (*'You got only 20% improvement now. That is a small percentage. If you got at least 50% improvement then you will feel like you got improved'*). These attempts could be considered as the therapist's communication skill to convince the patient in this particular situation. The patient agreed with minimal response ('yes', 'ahh') at those moments with what the therapist said in both situations. However, there was no evidence in this conversation whether the therapist has addressed the patient's concerns and demands formed as a result of the patient expectation (a functional based

recovery) sufficiently. This could be negatively influenced the future therapeutic relationship.

A patient-rated functional outcome measure can be recommended in this kind of clinical situation, which helps to avoid the incongruence between patient and therapist regarding the expected recovery. Because a patient-rated functional outcome measure provides the opportunity to the therapist to plan and progress the treatments according to the patient's expectation and perception (Kyte, 2015). This kind of collaborative approach possibly improves the therapeutic relationship and patient satisfaction (Kyte, 2015; Holmes et al., 2017).

### **Extract 15**

An incongruence also visible between patient and therapist in extract 15. This incongruence happened because of the patient referred to the physiotherapy treatment and given the physiotherapy treatment without identifying the actual patient expectation. This conversation was at the end of an interaction or the concluding interaction of a therapeutic section. From this conversation, it can be identified that the patient in this conversation was not aware that physiotherapy comprises active kind of treatments like exercise. Rather the patient expected passive kind of treatments from physiotherapy. So, this extract illustrates how the patient expectation influenced the satisfaction and in creating a positive therapeutic relationship. This interaction was taken from the private sector and it happened between an intern female therapist in her 20s and a male therapist in his 30s. The patient came to the physiotherapy department for his vertigo treatment.

**PTO4: Kanichuthanna exercise allam veetil poy cheyyanam.**  
**P7: Apo. Njan tablet onnum kazhikandae.**  
**PTO4: Venda. Physiotherapy il njan medicines kondu treat cheyyarilla.**  
**P7. Apo. Theerno. Ethraye ullu (*ethu ethraye ullo annu ulla bhavam*)**  
**PTO4: Athe. Njan exercises explain cheyyunna leaflet konduvaram (oru exercise leaflet konduvannu). Etha exercise leaflet. Njan evide padipicha exercise allam tick cheythittundu. OK?**  
**P7: (Smile) Ahaa...**

---

***PTO4: (You) have to practice all these showed exercise at home.***  
***P7: Then, didn't I have to eat tablet?***  
***PTO4: No, in physiotherapy we do not treat with medicines***  
***P7: Then finish. Only this (an expression like only this much)?***  
***PTO4: Yes, will give the leaflet explain about exercise (bring an exercise leaflet). Here is the exercise leaflet. I ticked all the exercises that I taught (you) here. OK?***  
***P7: (smile) Aha.***

The above interaction denotes a concluding phase of a treatment session. In this conversation, the therapist tries to conclude the treatment session by providing advice in the form of an assertion [*(You) have to practice all these showed exercise at home*]. Then, the patient actively expressed his doubt to the therapist regarding the treatment and the expressed doubt is considered indirectly linked with what the patient expected from the physiotherapy. This expectation may be formed from the patient's lack of awareness about physiotherapy. Or it can be identified that an uncertain expectation the patient had about physiotherapy. The similar kind of experiences shared by different patients during the time of the interview is given below:

*'I thought in physiotherapy we got an oil massage kind of treatment' (P22).*  
*'I thought Physiotherapy is some treatment in which they give heat using machines'. (P24).*

*'Initially, I am not sure what they going to do. So, I felt fear about pain... I thought if they forcefully pull or mobilize my shoulder... So, initially, I have doubt do I need to attend physiotherapy or not. But come here, because of doctoral reference'. (P31)*

The above examples illustrated the various expectations the patient's had about the physiotherapy. According to Hills and Kitchen (2007b) The patients' beliefs (expectation is someone's belief about what might happen in the future) about the doctor prior to the visit played a significant role in their evaluations of the doctor, irrespective of what (s) he did or was perceived to have done. Therefore, by creating a positive expectation the patients' satisfaction with the visit can be increased and thereby it helps to build a better therapeutic relationship. From the above quotes of (P22, P24, P31) it can be identified that all these patients considered physiotherapy was a passive form of treatment. However, an uncertainty can also be identified in all of their expectations. The patient in extract 10 also expected a passive form of treatment from physiotherapy (*didn't I have to eat tablet*). So, in another aspect, the doctor's (as mentioned in chapter two all most all the patients from both private and public sectors were referred to the physiotherapy setting through the doctor) or the therapist's miscommunication or lack of awareness about the patient's actual expectations. The quote below describes the perspective of a therapist about the patient's reference to physiotherapy without identifying the patient's expectation.

*'The patient's expected something, but they direct here. So they came here and attend because of doctoral reference. That kind of patients has reduced the interest to attend and make the bond with us' (PTP19).*

*'Some patients do not like to do physiotherapy. They like passively to take medicines and reduce symptoms. Their symptom may be reduce; but actually the pathology will be there. If a patient comes to the doctor for treating the same symptoms more than once or twice then doctor's usually referred them to*

*physiotherapy. These type of people say I felt better improvement or I sleep well while taking medicine, but now I feel pain' (PT19).*

On the basis of PTP19's perspective, it can be interpreted as the patient in extract 15 may be referred to physiotherapy treatment without considering his expectation by the doctor. According to Barron, Moffett and Potter (2007), the patients who strongly expect or believe that their health is in the hands of powerful others (that is physiotherapists) may not respond well to a home exercise programme. On the other hand, the patients with a strong internal locus of control may benefit from self-management strategies and feel frustration with more passive treatments (example, use of electro-physical agents or hands-on treatments) (Barron, 2007). So, this realisation will help the therapist to create a positive bond with the patients. This kind of realization from the initial interaction itself enable the therapist and patient to make a better decision together (in this case may be referred back or discuss with the doctor).

Patient dissatisfaction evident in this extract in the form of verbal response (*'Then finish. Only this'*). Here, patient reply (*'then finish. Only this'*) to the therapist's explanation (*'No, in physiotherapy we do not treat with medicines'*) was found not enough to satisfy the patient in the extract 15. So, as explained at the beginning of this chapter asking the patient about their expectations at all stages of their care is necessary to attain patient satisfaction as well as to create a positive therapeutic relationship. The paternalism that identified in this conversation could be negatively influenced patient-therapist relationship. So considering patient expectations as well as to address the patient uncertain expectation about the physiotherapy treatment is important to develop patient satisfaction as well as to create the better therapeutic relationship.

### **8:3 Synthesis of the result**

Table 8.1 comprises the synthesis of the relevant findings obtained in each stage of data analysis regarding the topic patient satisfaction and the therapeutic relationship.

**Table 8:1 Synthesis of the findings of chapter 8**

Sub-themes	Textual	Interpretive	Explanatory
Incongruence between patient and therapist	Patient concerns in the form of worries Patient illustrated active demands in the form of priorities 'I language assertion' Persuasion The patient expressed expectation as a doubt Therapist assertion	Outcome measure Patient expectation and age lack of effective patient education, Miss communication Or lack of effective communication with the patients Patient's belief Health professionals unawareness of patient expectation Attitude as an expert	Paternalistic vs. patient-centred Age

Patient expectation and its link with therapeutic relationship were explained using the subtheme incongruence between patient and therapist. Patients expressed concerns about their expectation in the form of worries and the demands in the form of priorities as the result of incongruence that happened between the patient and therapist. So, identify patient expectation as early as

possible and provide the treatment according to that is considered as essential to avoid the kind of incongruence that discussed in this chapter. Patient-rated outcome measure could be a recommended method to the therapists to know about the patient expectation at all stages of the therapeutic process. Also, it encourages the patient to take an active role in the decision by sharing their expectations. However, certain patients may not be preferred to take an active role in decision making. So, it is essential to aware the therapist about whether or not the patient prefers to take active role in decision making, which in turn facilitate effective implementation strategies in decision making and thereby improve the therapeutic encounter. Patient with different age group may be possessed different expectation. So, it is suggested to the therapist that to identify the variations in the expectations of the patient with the different age group.

In this chapter, the 'I language assertion' and the persuasion are the approaches noticed from the therapist's side to handle the patient's concerns and demands. Paternalism could be recognised in those kinds of approaches that are particularly expressed in the situations that discussed in this chapter. The paternalism identified in this chapter possibly influenced the therapeutic relationship in a negative manner. So, handle the raised concerns and demands of the patient in a mutual way (by sharing the power) could be a recommended method for improving patient satisfaction. Also, therapist should aware about how to use the knowledge of power as an expertise in a positive way to enhance patient satisfaction.

Patient raised the doubts while they recognised that they could not receive the expected treatment. Up to a certain extent, the health professionals are responsible for this. That is, lack of communication or miscommunication that



occurred between the health professionals (the medical doctor who referred the patient to the physiotherapy department) and the patient might be the reason behind it. In this kind of situation, from the initial interaction itself, it is recommended to conduct an effective communication with the patient by the therapist to identify the patient's expectation. Therefore, it is essential to identify the patient expectation by the doctor before referring the patient to the physiotherapy treatment or the physiotherapist before providing the treatment to the patient. Also, ensure that patient is provided with enough information by the therapist or the doctor about the physiotherapy.

#### **8:4 Chapter summary**

This chapter explained the importance of patient expectation and its connection with the therapeutic relationship by using three extracts. Initially, adopt a mutual therapeutic relationship approach, which is found essential to identify patient's expectations and to improve the congruence between patient and therapist especially in the matter related to recovery. Secondly, this chapter found that lack of awareness about patient expectation could be reduced patient satisfaction and possibly influences the therapeutic relationship in a negative manner. It is better to use a mutual therapeutic relationship approach rather than the paternalistic approach to handle the patients raised concerns or demands as a result of incongruence or towards a patient, who illustrate reduced satisfaction. The findings suggest that it will help the therapist to identify the importance of creating a mutual therapeutic relationship with the patient to identify patient expectation, to improve the patient satisfaction and to improve the congruence in the Indian outpatient physiotherapy clinical context.

## **Chapter 9: Discussion and Conclusion**

### **9:1 Chapter introduction**

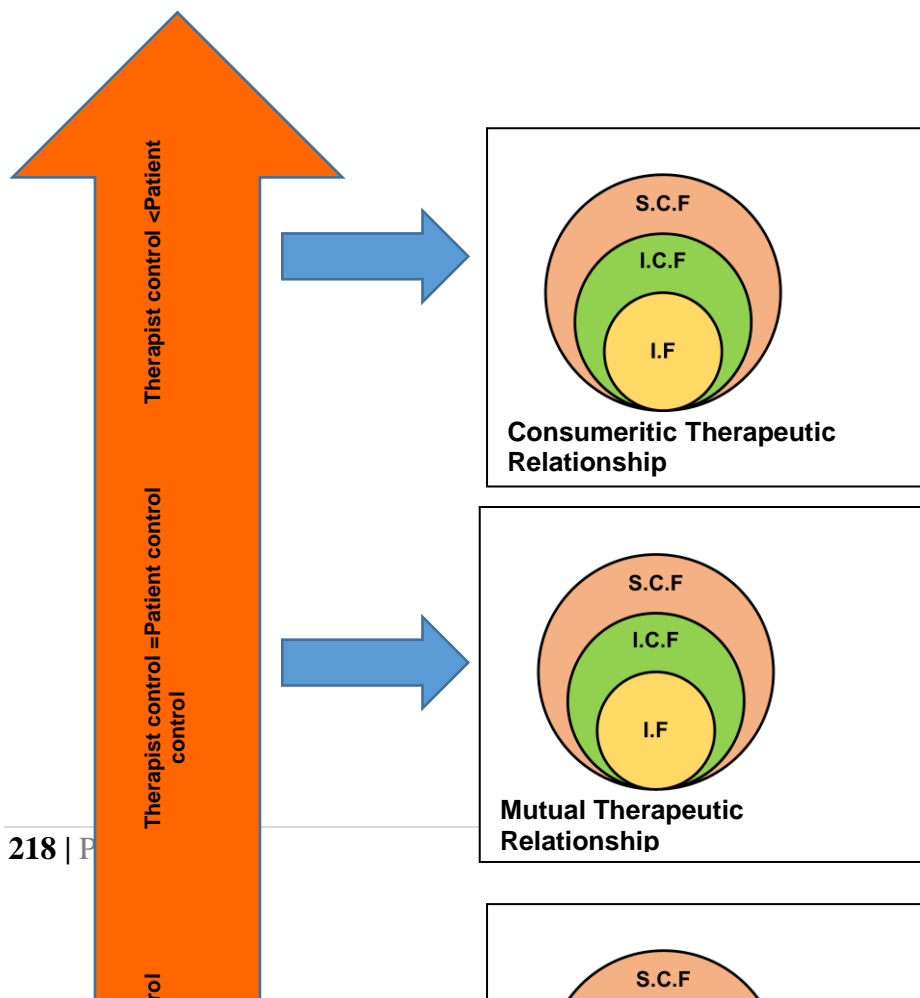
The aim of the study was to identify how interactional features, the contextual elements and issues of power is associated with the patient-therapist relationships in an Indian outpatient physiotherapy setting. This study identified these factors are interconnected with each other and based on these findings three models of therapeutic relationship was constructed. This chapter will discuss these three models and the theory that was formed on the basis of these three models in details.

The first section of this chapter explains the theory that formed from this research and provides detailed discussion around each model of therapeutic relationship that was used to form the theory. The chapter also describes how the three factors (societal level, institutional level contextual and interactional) are involved in each model and how elements associated with these models negatively, and positively influence the formation of the therapeutic relationship. This chapter compares the findings of this study with previous literature, the

recommendations and implications for practice and research, the main strengths and limitations of the study and the overall conclusions of the thesis.

**9:2 Theory of the research: the linear relationship of three different models of therapeutic relationship constructed from the study.**

From the ethnographic critical realist perspective, the overall study identified the connection between societal level contextual factors, institutional contextual factors and interactional features in the therapeutic relationship. In this study, the societal level contextual factors, the institutional contextual factors and interactional features denoted the elements of social practice, discourse practice and the text features of Fairclough's CDA respectively. The findings of this study will be discussed in this chapter on the basis of three main models which are: the mutual therapeutic relationship, the consumerist therapeutic relationship and the paternalistic therapeutic relationship. These three models are forming a linear relationship with each other. The diagram below (figure 9:1) illustrates the theoretical representation of this study.



As seen in the diagram, the three different models of the therapeutic relationship that constructed from the data are used to build up the linear theoretical model. The one end of this linear theoretical model is the paternalistic therapeutic relationship, in which the therapist possessed more control over the patient in their relationship. The other end is the consumerist therapeutic relationship, in which compared to the therapist the patient had more control, and the mutual therapeutic relationship is the mid-point or balance between the two, when the patient and the therapist have approximately equal power.

This is similar to the description by Henson (1997), which describes mutuality as midway between paternalism (focus on provider) and autonomy (focus on the patient). So, extremes of autonomy or paternalism can create conflict in provider-client relationships (Henson, 1997). However, to achieve mutuality it is essential to balance the power of paternalism and patient autonomy.

In the field of medicine, there already exist models of therapeutic relationship, which are specifically focused on the social aspects of the therapeutic relationship (Emanuel & Emanuel, 1992; Szasz & Hollender, 1956).

The models included in the theory of this study compare with the doctor-patient relationship models described by Szasz and Hollender (1956) and Emanuel and Emanuel (1992). Szasz and Hollender (1956) introduced three basic models of doctor-patient relationship, which were: the activity-passivity, guidance-co-operation and mutual participation models. Emanuel and Emanuel (1992) introduced four types of therapeutic relationship models: paternalistic, informative, interpretive and deliberative. The activity-passivity and guidance co-operated model of Szasz and Hollender (1956) and the paternalistic model of Emanuel and Emanuel (1992) are similar to the concepts of the paternalistic therapeutic model of this research; as these models assume that doctors are experts and can determine objectively the best interests of their patients. That means these models illustrate that the clinician has more control than the patient. Even if the physician has more control in the activity-passivity model and guidance co-operated model, the strength of physician control can vary in these models. In the activity-passivity model the physician takes decisions for the patient, who is completely inactive; whereas in the guidance co-operative model the physician will tell the patient what to do and later the patient will comply or obey.

The mutual participation model of Szasz and Hollender (1956) is similar to the mutual therapeutic relation model of this study - in both of these models the patient and clinician share power. The interpretive model of Emanuel and Emanuel (1992) is also similar to the mutual therapeutic relationship. In the interpretive model, the physician possessed a role of an adviser or counsellor

and the patient an autonomous level of self-understanding (Emanuel & Emanuel, 1992). That is the patient needed a certain level of understanding about who she or he is and the ability to choose the right option, which is suitable for their identity. So, these roles provide the opportunity for the patient and therapist to share power.

The consumerist approach in the therapeutic relationship was not mentioned by Szasz and Hollender (1956). This is probably because the concept of health care consumerism was not seriously considered until the 1970s. In the 1980s, health policy in many countries was strongly influenced by the promotion of consumerism as part of the market ideology (Marincowitz, 2004). So, the informative model of Emanuel and Emanuel (1992) is similar to the consumerist model of therapeutic relationship. In this model, the patient has entire control to take the decision over his or her disease condition.

However, the consumerist kind of relationship in health care has been criticized because it represents a departure from societal expectations of doctors, in which the doctor understand patients' values and how patients' illnesses impinge on their values and tailor their therapeutic recommendations based on this knowledge (Opera, 2009). In addition, the consumerist model has been criticised for reducing doctors' roles to technical ones, and prohibiting doctors from giving recommendations, as this would impose their values to patients, and lacks the caring approach (Opera, 2009).

While analysing the extracts it was clear that this study found certain features associated with each of these relationship models. The mutual therapeutic relationship was identified between the patient and therapist when age and gender were similar or the same. The consumerist therapeutic

relationship model was only found among the extracts in the private sector. The paternalistic model was only found among the extracts related to the public sector.

### **9:3. The basic framework of the three therapeutic relationship model**

The three models of therapeutic relationship used a common framework, which is adapted from Fairclough's concept (2001). The framework was developed on the basis of three elements in three layers: societal level contextual factors (outer layer), institutional level (intermediate layer) contextual factors and interactional features (inner layer). These elements interlinked in each model. For instance, in mutual therapeutic relationship model, the wider societal level contextual factors and the institutional level contextual factors and interactional features were identified as interlinked each other. This study considered these contextual factors (societal level and institutional level) and the interactional features as the activities or the power that related to the participants that negatively or positively influenced the creation of a better therapeutic relationship. The diagram below (figure 9:2) demonstrates the common framework of the three models of therapeutic relationship and the next section will explain each model in detail.

Based on the situations in different extracts the interactional features presented in the inner layer of each model may vary. The societal and the institutional factors presented in the middle and outer layer of each model is based on the interactional features that affected the inner layers. So, the contextual factors appear in one model could have influence over other models. For instance, religion is present only in the outer layer of mutual therapeutic relationship model (fig 9.3) based on situational features of interaction notified in

this study; but the possible influence religion on the consumerist and paternalistic model could not be discarded.

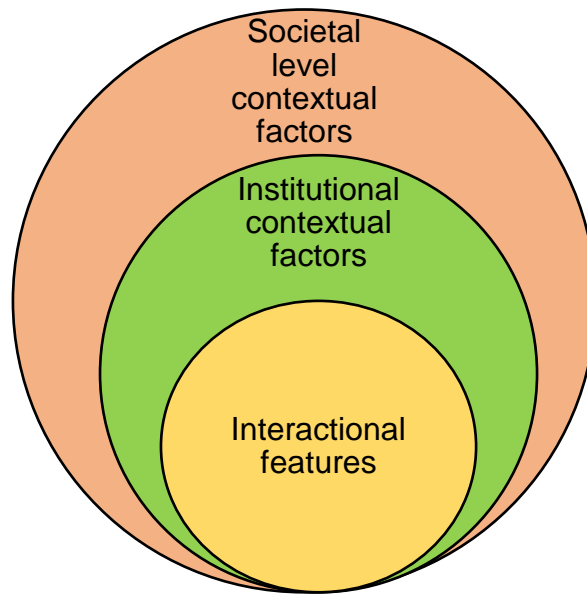


Figure 9:2. The common framework of three model of therapeutic relationship that constructed from the data. (Adapted from Fairclough, 2001)

#### **9:4 Three models of therapeutic relationship**

The next section will discuss mutual, consumerist and paternalistic therapeutic relationship models in detail, and the elements associated with these models and how it influences the therapeutic relationship in the context of this particular study.

##### **9:4:1 Mutual therapeutic relationship model**

Figure 9:3 illustrates the diagrammatic representation of the mutual therapeutic relationship. The evidence identified in different chapters of this study emphasises the necessity to form a mutual therapeutic relationship to enhance the therapeutic relationship. According to this study, the mutual therapeutic relationship was possible through certain activities (contextual factors and interactional features) that lead to mutual participation and vice-versa. Such



activities were found from both patient and therapist in different situations, and in different chapters. This mutual power in patient-therapist interaction was identified in the extracts presented in chapter 7 and some of the extracts in chapters 6 and 8.

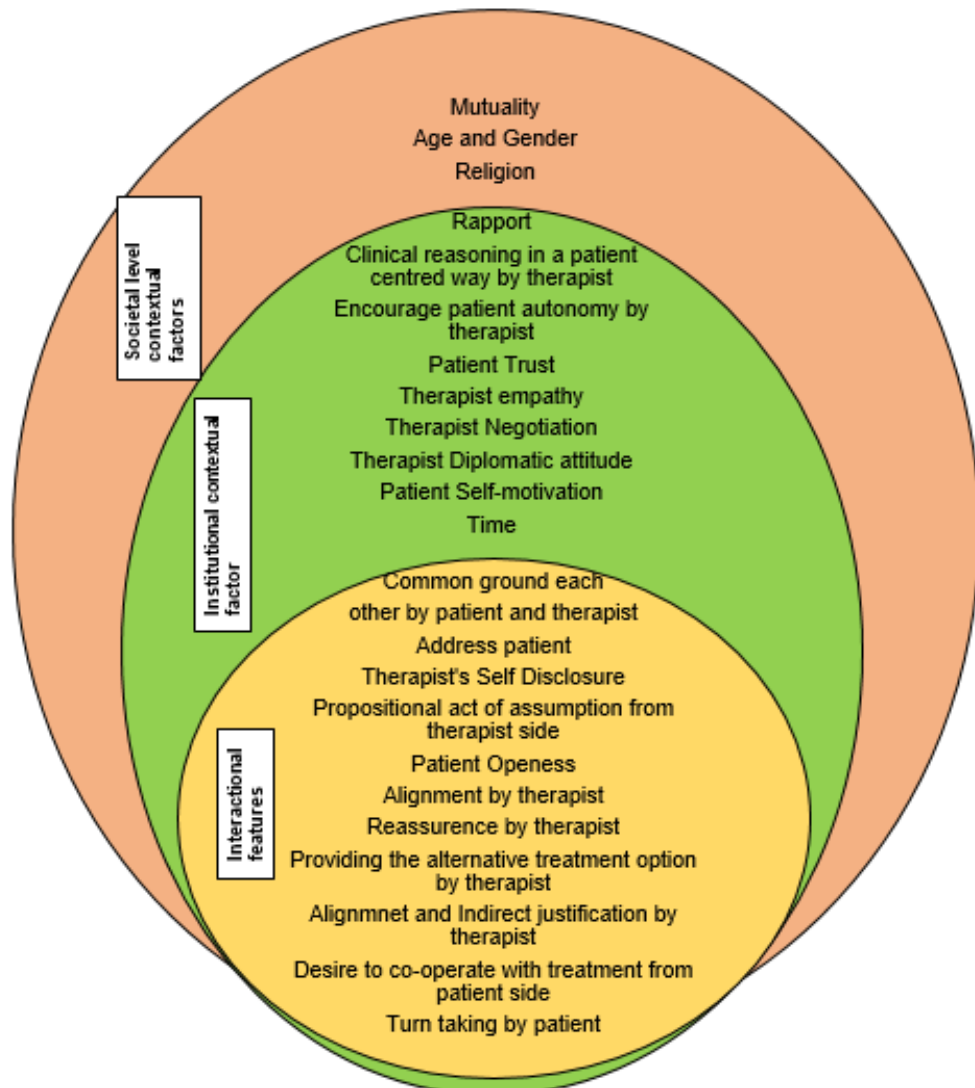


Figure 9: 3. The mutual therapeutic relationship model

**Common ground**

**Common ground-age- gender and rapport**

According to this study, finding common ground is considered as a significant element to create a mutual therapeutic relationship by creating better rapport between patient and therapist. Rapport is the relative harmony and smoothness of relations between people (Duchan & Kovarsky 2011). According to Duchan & Kovarsky (2011), it is essential to study how rapport is created in the clinical relationship, which in turn, influences accomplishment of therapeutic goals.

Age and gender were identified as societal factors that reduced the power between patient and therapist. That is, common ground finding conversations and an attempt to create a better rapport through common ground was found between patient and therapist with same age group and gender in this study. According to Defibaugh (2014), a mutual power exists in common ground identification conversations. So, in that sense a presence of mutual power can also be identified in such kind of conversation. None of the previous literature regarding solidarity explained this kind of connection in health care before.

In this study, the therapists in extracts 7, 8, 9, 10, 11 and 12 in chapter 7 found common ground with the patient in their similar gender and age group by sharing their power. This, in turn, enhanced rapport between patient and therapist in those conversations.

Almost all extract in chapter 7 could be an example of how the intersection of the age and gender ideology shape the therapeutic relationship. This kind of ideological intersection could be difficult to identify in Foucault analysis; this is discussed in chapter 2. Marwaha, Horbin & Mclean (2010) identified gender as a factor of interactional asymmetries in therapeutic relationships in the Indian physiotherapy context. In addition, Fochsen, Deshpande & Thorson, (2006)

found gender was a factor behind the power disparities in doctor – patient interaction in the context of India. My study is possibly an extension of those findings, especially, extract 8, 11 and 12 in chapter 7 where the interaction changed and power is shared when common ground is shared on the basis of age and gender.

### **Common ground -Religion- Address-Rapport**

One of the most important societal factors that was identified in this study that possibly helps to construct common ground was religion. This was done by addressing the patient according to their religious belief and through therapist self-disclose about their religious beliefs to the patient. This was identified as the interactional strategy used by the therapist in this study to create a rapport in the conversation and enhance the mutual therapeutic relationship.

Knowing the patient's religion helps the health professional to identify how to address the patient, especially, with older patients, according to their religious beliefs on an interactional level. That is, addressed the patient (especially, the older patients) according to their religious belief is a form of interactional strategy to show respect and alignment with the patient. This is a way of accepting the power of the patients (the power that the patient possessed in the society) by the therapist in the institutional (clinical) contextual level. In turn, this was considered to build rapport between patient and therapist. This finding is in line with a study conducted in the socio-cultural context of Ghana (Salifu, 2010). In that study Salifu (2010) identified that linguistic forms used by speakers to address or refer to each other have their socio-cultural meaning; not only used for the purpose of identifying the addressee, but also for communicating other social meanings and attitudes like politeness, power and solidarity.

## **Common ground- Religion – Self-disclosure- Rapport**

Revealing their own religious belief to the patient was an attempt from the therapist to show their alignment with the patient and thereby create a mutual therapeutic relationship. Revealing their religion was part of the self-disclosure strategy used by therapists. Self-disclosure is considered as the willingness and ability to reveal one's own inner states to another person, to make one's needs known, to share one's thoughts and feelings, giving the other person access to one's subjective world (Jordan, 1986). Zink et al. (2017) identified that health professional's self- disclosure to patients helped to build rapport between them in the context of emergency care department, which is similar to the finding in this thesis. That is, revealing the religious belief of health professional was identified as a factor to build patient-therapist rapport.

Previous literature discussed both disadvantages and advantages of self-disclosure in health care settings. In this study self-disclosure was a factor which helped to create a mutual power between patient and therapist and thereby improved the therapeutic relationship. Much of the previous literature support these findings (Knox & Hill, 2003; Frank, Breyan & Elon, 2000; Lussier & Richard, 2007). All those studies identified that self-disclosure enhanced the therapeutic encounter. The main disadvantage of self-disclosure previously identified was that physicians cross a boundary that separates their personal and professional roles (Farber, Novack & Berin, 1997). For instance, if health professionals moved away from the professional role and made the relationship with the patient more like friendship, then the implications are different from those of the therapeutic relationship. That is friends might have the right to make demands beyond the professional domain (Farber, Novack & Berin, 1997). So the patient might

demand more consultation time, display more signs of friendship, become too curious about physicians' personal lives, and even resort to seduction.

So, before deciding whether to reveal something about themselves, physicians must know their patients well (Lussier & Richard, 2007). They should have a single goal in mind when they do reveal themselves: to help their patients. It is also important to determine how much self-disclosure is necessary (Lussier & Richard, 2007).

Therapists in extracts 10, 11 and 12 in chapter 7 illustrated self-disclosure to find common ground with their patient and thereby to share their power with the patient. The therapist in extract 12 revealed his religious belief to find common ground with the patient.

### **Patient centred clinical reasoning- Propositional act of assumption- Mutuality**

This study identified that if patients raised concerns a patient centred way of clinical reasoning could be a better way to build up the mutual power in patient-therapist interaction. According to this study, this is possible through using the propositional act of assumption as an interactional strategy. A study related to the doctor-patient imbalance in Indian healthcare context identified that doctors perceived themselves as the person with the prime aim of making patients obey their instructions. So, doctors usually try to convince patients if they raise concerns by providing information (Fochsen, Deshpandae & Thorson, 2006). This is what was seen in chapter 8 (extract 13 and 14). In those extracts when the patients raised their concerns about their recovery, the therapist tried to convince the patient as a medical expert. So, these extracts were similar to what Fochsen, Deshpandae and Thorson (2006) discussed in their study. In this kind

of situation, patient centred clinical reasoning found in chapter 7 (extract 8) could be helpful to balance the power of both patient and therapist. A study from therapist perspectives for treatment and recommendations conducted in UK physiotherapy settings also identified that practitioners usually use accounts when their patients expressed concern (Parry, 2009). This type of account from practitioners could increase persuasive force (Parry, 2009), so that patients might feel that their concerns were not considered adequately (Parry, 2009). To avoid this Parry (2009) recommended therapists ensured that patient concerns were addressed adequately. The findings of this study support the suggestions made by Parry (2009). According to this study whether or not therapists provided accounts to the patient about their concerns, a patient centred way of clinical reasoning was identified as the better way to address patient concerns and balance power. In addition to that, the evidence of this study identified a propositional act of assumptions regarding the patient social situation (already discussed in chapter 7), could be used as an interactional strategy to direct the interaction towards a patient centred way of clinical reasoning.

That means an investigation about the patient's concerns by using the propositional act of assumptions from the side of the therapist could have helped the patient to become active in this kind of situation. Clarify the therapist assumptions by asking it to the patient possibly help them to conduct a successful reasoning regarding the patient's non reducing symptoms. Previously, certain studies analysed the role of assumptions in making clinical reasoning (Durning, 2013; Arocha, Vang & Patel, 2005). Those identified that the making assumptions and clarify the assumptions regarding the patient and their context is usually a positive strategy that helps to the medical professionals to make a diagnosis and provide an appropriate treatment to the patient. This study also, identified that the

propositional act of assumptions allow the therapist to know or clarify their doubt regarding if there are any non-medical contextual factors associated with patients concerns (refer chapter 7 extract 8 and 9). This was considered as a cognitive way of creating mutuality or mutual therapeutic relationship.

However, Alfaro (2009) pointed out that inadequate clarification of preconceptions and inaccurate assumptions such as 'most indigenous people are alcoholics' or 'Young women tend to have more pain threshold' can negatively influence the clinical reasoning.

### **Encourage-Patient autonomy-Openness – Trust- Alignment -Mutuality**

Encouraging patient autonomy was identified as a clinical contextual factor that helped the therapist to share the power. This can be attained by providing different treatment options to the patient and showing alignment with the patient interest. Also, this study found that encouraging patient autonomy helped the patient to become more open while interacting with the therapist. This, in turn, was recognised to enhance the mutual therapeutic relationship.

Encouraging patient autonomy is considered as the cognitive level of initiation from one person to understanding another person (Henson, 1997). As mentioned early in this chapter mutuality is midway between paternalism (focus on provider) and autonomy. So, extremes of autonomy or paternalism can create conflict in provider-client relationships. If the patient is passive or the illness has diminished their autonomy in decision making then to avoid the possibility of paternalistic extremes, it is essential for the therapist to support and encourage patient autonomy. This, in turn, helps to balance the mutual therapeutic relationship (Marincowitz, 2004). Nessa and Malterude (1998) explained that autonomy could only be achieved through authentic interaction. According to

Nessa and Malterude (1998) perspective, an interpersonal mode of being is "authentic interaction; and they considered the genuine dialogue and dialogue-based openness are necessary to create an authentic interaction between patients and health professionals to reduce the imbalance of power. To encourage patient autonomy or to make them active in decision making the health professional become more or less consciously authentic (genuine) in their dialogue.

In that sense, this study identified that the openness of the patient was attained when the therapist encouraged patient autonomy and shared their power with the patient. So, according to the extract 7 in chapter 7 providing the alternative treatment option to the patient and showing the alignment with their treatment interest could be a way to encourage patient autonomy at the interactional level.

Much previous physiotherapy literature identified trust is an important factor in creating a better therapeutic relationship (Hills & Kitchen, 2007a; Hush, 2011). The review of literature in chapter 2 illustrated this. This study also identified trust is an important factor to create a mutual therapeutic relationship. According to Piippo and Aaltonen (2007), patient trust and autonomy were connected to each other. Piippo and Aaltonen (2007) identified that patients feel that trust increases as their experience of autonomy increases and in such situations power is not owned by any one person. This is similar to what this study identified in extract 7 in chapter 7. The patient took a turn in talking about his previous experiences, and expressed his autonomy, as a result of the trust that the patient felt in the therapist.



This alignment that was illustrated by the therapist in extract 7 to the patient could be identified as the reason behind the trust that formed between patient and therapist. So, according to this study illustrating alignment to patient belief or interest is a way that could be recommended to the physiotherapist to build a trust in the therapeutic relationship.

Therefore, from these, it is clear that patient autonomy, trust, alignment, openness all have a connection in creating the mutual therapeutic relationship.

### **Diplomatic attitude- Alignment- Indirect justification-Mutuality**

Diplomatic attitude is considered to help in building the therapeutic relationship on mutual respect. As mentioned in chapter 2 (therapist autonomy) in the current situation in India the position of the therapist is between (except in certain private clinic) the referral doctor and the patient. So, in this certain situation, the therapist attitude depends upon the referral doctor's opinion and the patient's interest. If the doctor and the patient have different opinion or interest, it is recommended to take a diplomatic attitude from the side of the therapist. This is what is illustrated by the therapist in extract 7 in chapter 7. This finding is aligned with Macdonald (2016) findings, who identified that the nurses use small talk in a diplomatic way to handle the unpleasant or challenging situation with the patient. For instance, interaction about traditional medicines was found as a common topic in the patient-therapist interaction in the Indian physiotherapeutic context. If the doctor and patient have opposite opinions about the traditional medicine, according to this study it is recommended to take a diplomatic attitude by the therapist.

Here, the therapist in extract 7 expressed his individual opinion (regarding the use traditional medicine), which could be identified as to illustrate his

alignment with the patient opinion. Also, the therapist provided an indirect justification to the doctor (higher authority) opinion, which is opposite to what the patient believes. So, in this way, the therapist in extract 7 illustrate respect to the opinion of either party. That is illustrating alignment with the opinion of the patient (if the therapists have or not have a specific opinion) and justify the conflicting opinion of the doctor possibly considered as an effective interactional strategy that can be adapted to the therapist to illustrate diplomatic attitude. This is also a cognitive way of demonstrating respect to either party (doctors and patient).

### **Empathy- Alignment- Reassurance- Mutuality**

Empathy is an effective way of creating mutuality with the patient whilst they express their emotion. Much of the previous literature in different disciplines discussed the importance of empathy in creating a better therapeutic relationship. In physiotherapy research, empathy is viewed as the fundamental component of the patient-therapist relationship. The majority of those studies explained the necessity to consider patient's pain and associated symptoms empathetically by the physiotherapist (Gyllensten, 1997; May, 2001; Gard, 2007; Hills & Kitchen 2007a; Kidd, Bond & Bell 2011; Del Bano-Aldeo et al., 2014; O'Keeffe, 2016). So those studies concluded that empathy was an important communication skill needed by the physiotherapist to conduct a positive interaction with the patient and create a better therapeutic bond.

Empathy can be expressed in different ways. According to Finset and Ornes (2017), most empathic responses not only succeeded by biomedical enquiry but also by different actions especially reassurance. Adams et al. (2012) identified that align most with the patient emotional response is one of the commonest ways the physicians used to convey their empathy. The therapists in this study

illustrated empathy in the form of alignment and reassurance. So, if the patient expressed their emotional experience to the therapist, showing alignment with their emotions or reassuring the patient can be suggested as an effective interactional strategy to illustrate empathy from the therapist side.

### **Self- motivation- Desire to co-operate with the treatment- Mutuality**

Patient self-motivation in the clinical context helps to enhance the mutual power in the patient-therapist interaction because being self- motivated means the patient took an active role in his/her rehabilitation process. In other words, patients desire to engage in rehabilitation that matches with the ideology of the therapist (to make the patient active or independent). This would be helped if both parties recognised the sense of mutuality. In this study, the patient used the desire to co-operate with the treatment as the interactional strategy to demonstrate self- motivation. For instance, in extract 6 in chapter 6 the patient compares his previous experience to illustrate tolerance of pain and is considered as the patient desire to co-operate with the treatment.

While patients illustrate self-motivation it becomes the therapist's responsibility to maintain the self-motivation of the patient. In this study, the therapist showed alignment with the patient and reassured the patient, who expressed self-motivation in the form of emotional expression.

### **Negotiation- Alternative treatment options-Mutuality**

This study recognised that using a negotiation strategy to make the patient compliant with treatment is an approach to illustrate mutual power. Sahlsten et al. (2007) identified that mutual power is a necessary precursor of negotiation. Much of the previous literature revealed negotiation is one of the elements that

influence patient participation (Roberts & Krouse, 1990; Roberts & Krouse, 1995; Gallant, Beaulieu & Carnevale, 2002; Sahlsten et al., 2007). In that sense, this study also identified that negotiation helps to ensure patient participation and thereby create a mutual therapeutic relationship between patient and therapist. Negotiation has been described as the shared responsibility and partnership-planning behaviours (Roberts & Krouse, 1990).

The therapist in extract 4 in this study illustrated negotiation by providing the alternative option for the patient when the patient expressed challenges to compliance with the treatment. Directly or indirectly the options given by the therapist are ways to make the patient active in decision making. The therapist in this study considered the patient's situational context before providing the alternative options. Previous studies also discussed the necessity of providing alternative options to the patient by considering patients' needs and the context of the patient's situation to negotiation (Lee et al., 2002; Landmark, Gulbrandsen & Svennevig, 2015).

### **Turn taking- Socio-cultural background – Mutuality**

According to extract 11 the patient's different socio-cultural background from that of the therapist might be an influence on patient turn-taking (take active turns in conversation; describes in chapter 3 section 3.6.2.2). One of the main factors that influence patient lack of initiation in turn taking could be associated with patient language fluency. According to Gorjian and Habibi (2015), turn-taking is one of the basic mechanisms in conversation, and the convention of turn-taking varies between cultures and languages. Therefore, the learners from other language and cultures may be find it difficult to take their turns naturally and properly as they would do in their mother tongue. So, while consulting the patient

from the different culture it is suggested to permit enough time to interact with such patients. This, in turn, helps the patient to take an active role in the interaction.

### **Socio-cultural background- Time- Mutuality**

Previous literature from physiotherapy recognised the importance of time in building the therapeutic relationship (May, 2001; Hills & Kitchen, 2007; Cooper et al., 2008; Hush, 2011). Time is identified as one of the external factors in chapter two to build up a better therapeutic relationship. In this study, the extracts 11 and 8 from chapter 7 pointed out that the therapeutic relationship could be better over time. Especially, in the case of a patient and therapist from different cultural aspects more time may be needed to build a therapeutic relationship compared to the patient and therapist from the same culture.

### **9:4:2 Consumerist therapeutic relationship model**

The figure 9:4 is the diagrammatic representation of the consumerist therapeutic relationship model that was found to have an influence on the patient-therapist relationship in the Indian physiotherapy context. This study discussed how the institutional and societal level contextual factors and the interactional features were linked to each other and how they influenced the therapeutic relationship. Consumerism offers more power to the patient to make decisions according to their needs (Harrison & Williams, 1999). The previous literature discussed both the negative and positive aspect of consumerism. According to the literature patients in the consumeristic approach will be more compliant with treatment (Fang et al., 2011). Fang et al. (2011) identified that consumerist patients differ from ordinary patients because consumerist patients are more

knowledgeable and aware of their health issues. So, their time with the physician is more productive (Fang et al., 2011). In that sense, more knowledgeable consumers may be better able or more willing to follow the physician's instructions (Fang et al., 2011). This, in turn, possibly enhance the therapeutic relationship.

However, this study identified certain situations that negatively influence patient compliance to treatment and how these situations linked to consumerist therapeutic relationship will be discussed in the next section.

This study identified that socio-cultural factors influenced the patient's treatment decisions while using the power of consumerism and the interactional strategy was noticed from patient to convey it to the therapist during their interaction.

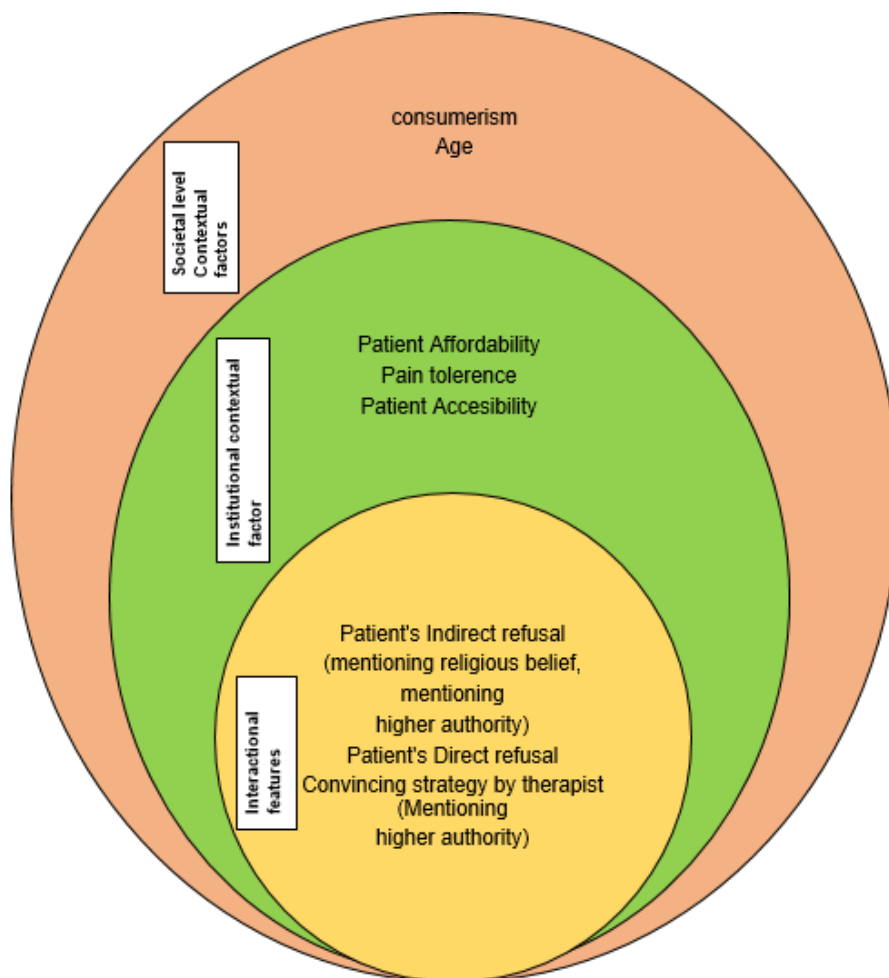


Figure 9:4 The consumerist therapeutic relationship model

### **Patient's affordability - Indirect resistance- Consumerism**

This study identified that in the context of Indian private healthcare people's treatment selection or compliance is often influenced by their financial situation. This finding is aligned with the findings of Fochsen, Deshpandae and Thorson (2006). According to the doctors working in the Indian private sector, the patient attending the Indian private sectors often requested the treatment according to their financial situation (Fochsen, Deshpandae & Thorson, 2006). So, the study concluded that finance is one of the main factors that influenced the patient's selection of treatment or compliance with the treatment (Fochsen, Deshpandae & Thorson, 2006). This study identified that the patients who could not afford treatments expressed it indirectly, as a way of resistance. This could have confused the health professional and negatively influenced the therapeutic relationship. The indirect resistance from patients found in chapter 5 (extract 2 and 3) was raised due to the reason of affordability. So if the therapist, or the doctor before referring to physiotherapy, identified the social situation of the patient and their needs initially, then they can provide the treatment options according to that. This could be helpful to avoid conflicts in such kind of conversations. According to Lonnoroth (2001), it has been argued that when healthcare providers' income is dependent on patients' willingness and/or ability to pay, the doctors tend to act in accordance with the patients' demand, even if they know that the requested treatment is incorrect.

As discussed in chapter 2 and chapter 5 in India only a limited number of public health care sectors offer physiotherapy treatment. So, during certain

situations patients from lower class and lower middle class families were forced to access the private sector for their physiotherapy treatment. Later on, this may have led to the possibility of discontinuing the full treatment because of affordability, or resistance from the patient to be compliant with the treatment. So, more government hospitals with physiotherapy units should be considered as a solution to avoid this financial situation for patients in India.

### **Pain tolerance - Indirect and direct resistance-Consumerist power- Age**

This study also recognised that patient fear of pain or less pain tolerance could influence patient treatment choice or compliance with treatment in the private healthcare sector. On the basis of the analysed extracts, the age-related ideological power possessed by the patient in this kind of situation possibly increased the imbalance of power between patient and therapist. That is, the age related power could have provided more control to the patient in that situation to illustrate their resistance to the treatment program. The patients involved in these situations showed resistance both directly and indirectly, which negatively influenced the therapeutic relationship. The patient with less pain tolerance illustrated their indirect resistance in different ways.

Plazzo et al. (2016) study illustrated that fear of pain and false beliefs regarding exercises were associated with patient direct resistance to compliance with physiotherapy treatment program. For instance, 'I quit practising because I didn't want to feel more pain'. This is a direct quote from a participant that found in the Plazzo et al. (2016) study. From this quote, it is identified that the patient pain was a factor for his/her direct resistance. So, pain related issues could be became a factor for patient's direct resistance. On the basis of the explanation provided by this study for extract 1 in chapter 5, pain was considered as the



possible factor behind the patient's direct resistance to comply with the treatment program.

One way that the patient illustrated the indirect resistance was by mentioning an ideological belief that was opposed to the philosophy of physiotherapy: karma in its passive form. So, this was considered as an example of how the passive form of karma negatively influenced a positive therapeutic relationship in healthcare settings. A study related to pain and Hinduism presented karma as an approach of acceptance (Whiteman, 2007). Psychologically, acceptance denotes an active process of taking in an event or situation (Whiteman, 2007). So, the people who believe in karma accept their pain and other symptoms. However, physiotherapy encourages the patient to take an active role in their disease state and the basic aim of the physiotherapy treatment is to make the patient independent. In that sense, karma is considered an ideological belief that opposes the philosophy of physiotherapy. This will create a clash between patient and therapist and negatively influence the therapeutic relationship. This is what explained in chapter one. So, it is essential to identify the patient's belief and provide the treatment according to that is essential to enhance therapeutic relationship.

Another way it can be explained is on the basis of acceptance-avoidance. As a believer in karma, the patient presented himself/herself as accepting their pain. However, the actual motive could be to avoid activities because of less pain or pain related issues. Similarly Marwaha, Horobin and Mclean (2010) identified that according to the Indian physiotherapist's perception karma is a cultural belief, which negatively influences patient adherence. So, patient resistance to adhere to the treatment again negatively influences the therapeutic relationship.

### **Therapist convincing strategy by mentioning higher authority**

Similar to previous study findings this study also identified that certain interactional strategies from therapist to convince the patients and reduce their resistance to comply with the treatment. This is similar to the findings from previous literature. But, the interactional strategies used by the therapist in previous studies were different from this study. For instance, Parry (2009) identified account (explanations) as an effective persuasion strategy by the therapist to reduce patient resistance. However, his study identified that a usual pattern of warning and /or mention higher authority as a convincing strategy from therapist to reduce patient resistance. This interactional strategy found in many situations (extract1, 2 & 3) in this study was found ineffective to convince the patient while they illustrate their resistance to comply with the treatment. Warning or mention higher authority is found as coercive form of power exert by therapist. It may be exerted consciously as a result of their previous experience with similar category of patients; for instance, the therapist attitude towards the older patient or it emergent suddenly as a reaction in their interaction. However, the adequate expiation could be suggested in this situation to avoid the conflicts between therapist and patient and enable the therapist to share their power with patient. Contextually, as explained in chapter 2 therapist the interactional pattern of mention higher authority may be the representation of therapist less autonomy in the clinic and higher social status of the physicians in the society.

### **9:4:3. Paternalistic therapeutic relationship model**

The figure 9:5 is the diagrammatic representation of the paternalistic therapeutic relationship model, which was considered to affect the therapeutic relationship in Indian physiotherapy context positively and negatively. The next section will discuss in detail how this particular model negatively and positively influenced the formation of a therapeutic relationship

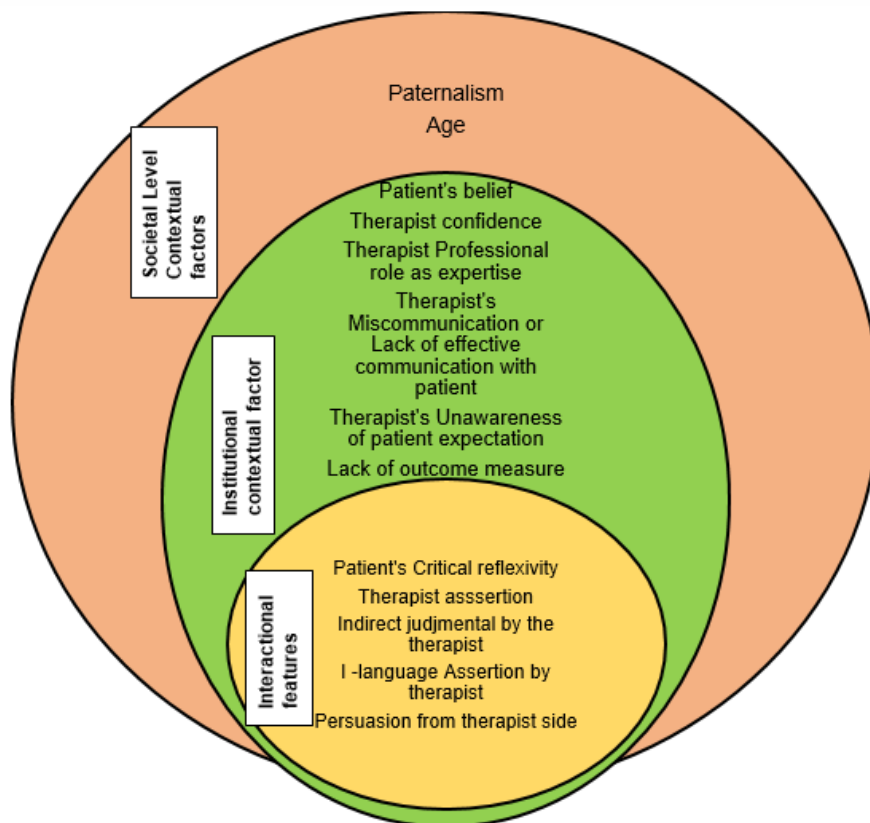


Figure 9:5 The paternalistic therapeutic relationship model

Szasz and Hollender (1956) correlated the physician-patient relationship in activity-passivity model with the relationship between an infant and a parent and guidance co-operated model correlated with a parent and an adolescent child model. Here in this study, the positive form of paternalism is similar to that guidance co-operated model and is identified to support patient compliance with the treatment, which also enhanced the therapeutic relationship. A negative side of the paternalism also can be identified from this study. Both these effects

(negative or positive) depending upon how the different elements associated with this approach were interpreted through various situations included in this study.

### **Patient's critical reflexivity- Patient belief-Paternalism**

This positive paternalism was found in chapter 5 (extract 5). In that situation, the patient was critically reflexive about the decision that had taken. Initially, the patient had selected traditional medicine, but the patient did not attain a successful outcome. Therefore, the patient expressed a critical reflection about that particular decision to the therapist. Also, the patient realised the condition had become chronic when she attended the physiotherapy session. In the light of these realisations, the patient sought help from the therapist. The patient was, therefore, ready and willing to cooperate with the physiotherapy treatment; in doing so the patient placed the therapist in a position of power (Marincowitz, 2004). Therefore, it could be recognised that the therapist spoke about the treatment by considering the patients' best interest (a guidance regarding the treatment selection) and thus expected the patient to cooperate and obey the therapist's decision without question. The patient in this context trusted the therapist as an expert in making decisions for her condition.

According to the extract 5 in chapter 6, the critical reflexivity of the patient illustrated that the patient lost her belief in the traditional medicine because the patient did not get a positive result from it. So in that situation, the patient expectation about modern medicine led her to the physiotherapy department for treatment. According to Barron, Moffett and Potter (2007), expectation originates from a belief; here, belief in physiotherapy treatment. So, it could be considered that the therapist took a paternalistic attitude after knowing the patient's belief.

Therefore, in this situation, paternalism was used for the patient's best interest by considering her belief in its wider aspect. So, paternalism in this instant created a better therapeutic relationship.

Almost all mode of treatment in Ayurvedha are a passive treatment (for instance: Uzhichil, Pizhichil, Kizhi, Dhara, Nasyam). In that sense, the philosophical underpinning of Ayurvedha could be considered as an opposite of what the physiotherapy based on (encourage the patient to take an active role in life). This is previously discussed in chapter one and six. It can be identified that patient in extract 6 of this study not only critic the treatment Ayurvedha (which based on opposing philosophical belief of physiotherapy) but also illustrated an interest to align with active physiotherapy treatment (exercise). This is a conflicting situation from what saw earlier under consumerist therapeutic relationship. There, the patient's alignment with the opposing ideological belief of physiotherapy (Karma) and illustrated resistance to complain with the physiotherapy treatment.

**Therapist assertion and indirect judgment- Therapist confidence – Therapist role as an expert – Therapist role as an expert- Paternalism.**

Similar to the previous study findings this research also identified therapist professional, as well as personal character have an influence on therapeutic interaction (Kidd et al., 2011; May et al. 2001; Cooper et al., 2008; Hills & Kitchen 2007; Harrison & Williams, 2000). Patients in Almost all reviewed previous studies perceived the positive aspects of therapist characteristics influence them in therapeutic interaction. However, patients participated in Harrison and Williams (2000) perceived not only the positive but also expressed the negative aspects such a regimental and controlling of therapist's characteristics. Extract 5 and 6 in chapter 6 is an example of therapist characteristics have an ability to exert a

positive form of power in therapeutic interaction. This is what Raven and French called referent power in their six forms of social power. Referent power is a form of actual or potential influence that relies on the personal characteristics of a person.

However, the previous study findings based on therapists' characteristics in therapeutic encounter were based on western context. In this situation, it could be recognised that regardless of Western or Eastern context and negative or positive manners the therapist characteristic possessed a significant role in therapeutic interaction.

In extract 5 the therapist exerted a paternalistic form of power through his confidence to make the patient comply with the treatment. Paternalism has been one of the traditional characteristics of the therapeutic relationship in health care and many of the previous literature focused on negative aspects of paternalism, especially in decision making process (Delaney, 2018). In Nimmon and Hayes (2016) study the physicians' perceptive paternalistic power as a negative form of power. But, extract 5 in this study is an example of how clinicians can exert the paternalistic form of power positively by using their professional characteristics.

The therapist in this study used assertion and indirect judgement as the interactional strategies to illustrate the power of knowledge to the patient. Most of the therapists, who took part in the interviews for this study discussed patients with musculoskeletal problems. Initially, patients approached the traditional medicines and if they did not get the successful outcome from the traditional medicine, then they approached the modern (western) medicine for their condition. This is what was identified in extract 7 in chapter 6 and also mentioned in chapter 2.

Most often in this kind of case, the patient's condition reached its chronic stage. In such situations, if the patients expressed a critical reflection about their first choice of treatment, then a positive illustration of the power of knowledge and adopted a guidance –cooperated model of paternalism was found to be helpful in creating a positive relationship with the patient. Or the guidance co-operated model was not an issue for the therapist to create a better therapeutic relationship

**Miscommunication or lack of communication– 'I language assertion'-  
Persuasion- Therapist role as an expert -Paternalism -- Age**

In all extracts included in chapter 8 were examples of incongruence between patient and therapist perspectives of recovery, mainly because of miscommunication or lack of communication. For instance, in extract 14 in chapter 8, it was apparent that the patient's perception of recovery was different from that of the therapist. This situation is somewhat similar what was described by Talvitie and Pyoria (2006) related to stroke patients. In their study, the therapist recommended exercise based on the problems noted in the analytic test performance. However, the patients and care givers worried about the patient's ability to cope with the environment and expressed their concerns. So an incongruence happened between the therapist perspective and patient and caregivers expectation in that study. As in the present study Talvitie and Pyoria (2006) identified this occurred as the result of lack of effective communication between the patient, care giver and the therapist.

The concerns raised by the patients in extract 13 and 14 were considered as a result of this miss-communication or lack of communication. The therapist used persuasion and 'I language assertion' strategy to handle the patient, when they raised concerns in this particular situation. But, this approach, was done in

a paternalistic way in the conversations in chapter 8 and it was found to negatively influence the therapeutic relationship and led to the possibilities to affect the patient future compliance to the treatment. 'I language assertion' could be beneficial in certain situation to illustrate positive assertion. Extract 13 in chapter 8 is an example that illustrates the possibility of how the expression of 'I language assertion' influenced the therapeutic relationship in a negative manner. The power of knowledge as a medical expert could be the reason behind the expression of 'I language assertion'. In that sense, a negative aspect of the use of this power of knowledge can be visible. This is opposite to what was identified in extract 5 in chapter 6, in which the therapist demonstrated knowledge that positively influenced the patient in that situation. So, it is recommended that while interacting with the patient, the therapist should be aware about the situation before using 'I language assertion'. Also, the therapist tried to persuade the patient by educating them about their recovery, but this was not enough to satisfy the patient.

As mentioned in chapter 2 several previous studies conducted in the context of developed countries also found that patient expectation was an important factor in creating a better therapeutic relationship (Hills & Kitchen, 2007; Basely, 2010; McPherson, Kayes & Basely, 2011; Fuentes et al., 2014; Keffee et al., 2016). Therefore, to identify patient expectations and act accordingly is essential to create a positive therapeutic relationship in the context of physiotherapy.

So, rather than a paternalistic approach, a mutual power sharing could be recommended to act upon the matter of patient expectation, which in turn affected patient satisfaction. Studies conducted in the rehabilitation context of Korea found that a cognitive empathetic style of communication has a significant



correlation with patient satisfaction and compliance (Chang, Park & Kim, 2013). Parry (2009) identified a timely explanation from the practitioner's side is necessary to avoid the issues related to patient expectation. In chapter 7 the therapist conducted a patient centred way of clinical reasoning by using the interactional strategy propositional act of assumptions to handle patient concerns and to create the mutual therapeutic relationship. However, in this particular situation, the propositional act of assumptions as a strategy to handle the patient concerns raised as the result of incongruence between the patient and therapist may or may not be effective. So, may be further research is needed in this area.

In the case of patient expectation, therapist previous experience about patient with different age group, could be considered as reason to adopt a paternalistic attitude by the therapist. That is, chapter 8 discussed the young patient perception about the older age patient's less satisfaction. So this kind of perception could be influenced to adopt a paternalistic attitude by the therapist without considering the actual expectation of the patient. Or without understanding the fact that patient expectation may be vary with different age group.

### **Unawareness of patient expectation- Patient rated outcome measure**

#### **-Therapist's Assertion-Paternalism**

Doctor's unawareness about patient expectation before referring them to the physiotherapy treatment or physiotherapist unawareness about patient expectation before providing the treatment could have negatively influenced patient satisfaction. This way of referring or providing treatment is the typical example of exertion of paternalistic power. This, in turn, become a barrier to create a better therapeutic relationship.

In this kind of situation, patients raised their concerns or doubts regarding their expectation or their expected treatment. The response of the patient in extract 15 is an example of that. So, use of an adequate interactional strategy to identify the patient expectation is recommended to handle this situation rather than providing a simple assertion about what the physiotherapy is. Certain variations can be seen in the use of 'therapist assertion' as an interactional strategy under the paternalistic therapeutic relationship model. Earlier under paternalistic therapeutic relationship model, therapist's assertion identified as a positive interactional strategy that possibly enhances therapeutic relationship (while discussing the situations of extract 5 in chapter 6). However, according to the interpreted situations of extract 15 rather than providing a simple 'therapist assertion', it is recommended to use another appropriate interactional strategy to identify patient expectation. So, from this, it is apparent that the effectiveness of therapist assertion under the paternalistic model depends on the situation where it is used.

In the institutional contextual level, it was identified that the introduction of a patient-rated outcome measure could be a useful method to share power and to avoid incongruence between patient expectation and therapist perspective up to certain level. So, one of the possible ways is the introduction of a patient-rated outcome measure, which is rarely found in the Indian physiotherapy context.

## **9:5 Implication for practice for the Indian physiotherapist**

### **Communication skill**

Interpersonal communication skills, including empathy and negotiations, are factors that are recommended by this study to enhance the mutual therapeutic relationship and thereby create a better patient-therapist relationship. Knowing

the patient's religion and addressing the patient according to their religious belief is one of the recommended strategies to improve therapeutic relationship. This study suggests that self-disclosure has a positive influence in creating a better therapeutic relationship. However, before deciding whether to reveal something about themselves therapists must know their patients well (Lussier & Richard, 2007). The therapist should have a single goal in mind when they do reveal themselves, which is to help their patients. It is also necessary to keep in mind about the possible disadvantages of self-disclosure. While interacting with the patient, the therapist should be aware about the situation before using 'I language assertion'.

Quality training sessions on communication skills are suggested for Indian therapists to handle the challenges that they face when communicating with patients of a different age group. It could be useful to develop certain method or framework to evaluate the communication competences of the therapist (Nimmon & Hayes, 2016); for instance, Canada's CanMEDS (Frank, Snell & Sherbino, 2017). This will help to identify the specific needs of the physiotherapist to improve their communication skill. This, in turn, may be useful in constructing group or individual continuation of training or education programs for occupationally active physiotherapist (Amoudi, 2017).

There is also need to introduce communication skill training in physiotherapy curriculums to improve communication (Gazbare, Rathi & Sartape, 2017). The interaction strategies that this study found positively influence the therapeutic relationship were as follows: alignment with each other's' views, openness, reassuring the patient, patient's illustration of desire to co-operate with the treatment and critical reflection by the patient about their previous unsuccessful choice of treatment strategy.

## **Make the patient active in decision making**

It is recommended to the therapist to develop strategies that ensure the patient's active participation in therapeutic interactions. According to this study, encouraging patient autonomy and consideration of patient concerns in a patient centred way are the suggested methods to ensure active patient participation in the healthcare interaction. However, before adopting a patient centred approach or encouraging the patient to take an active role in decision making it is suggested for the therapist to determine whether the patient prefers the patient centred care and to take an active role in decision making (Pluut, 2016).

## **Attitude**

Diplomatic attitude can be suggested to the physiotherapist to use as a cognitive method to illustrate a mutual respect in the conflicting situation to maintain a better therapeutic relationship. According to this study diplomatic attitude can be suggested to the physiotherapists who handle the situation in which the patient has a different opinion from the doctor who referred the patient to physiotherapy. Especially, in the matter of traditional medicine.

## **Expectation**

Consider patient expectation and provide the available treatment options according to their expectation are the suggested approaches to enhance the mutual therapeutic relationship. For instance, the therapist, before providing treatment to the patient and the doctor before referring the patient to the physiotherapy, it is essential to identify the type of treatment strategy that the patient believes in or expecting (passive or active). Introduction of patient-

reported outcome measures is highly recommended in the Indian physiotherapy settings to identify patient expectation. Different types of outcome measures been widely used internationally in many developed countries for decades and are now slowly making their way into routine clinical practice all over the world. There are certain barriers to introduce outcome measure in the Indian context, with language considered as the main barrier (Mehta & Grafton, 2013), as most of the established outcome measures are in English. So, validation would be needed to transfer to local Indian languages (Mehta & Grafton, 2013). Therefore, support and initiations from both national and state physiotherapy associations, from care-providing organisation, and co-operation from physiotherapists are necessary to tackle the existing barriers to the introduction of outcome measures in Indian physiotherapy settings (Mehta & Grafton, 2013).

#### **Support from Government side: Patient affordability and accessibility**

The government can contribute to the issues related to patient's affordability and accessibility to physiotherapy treatment, which in turn was identified as an influence on patient compliance and the therapeutic relationship. That is, by introducing physiotherapy in more government hospitals including sub-district hospitals as well as the formation of community rehabilitation units would be helpful for patients from different social status to access physiotherapy.

India's current government introduced a health care plan in the 2018-2019 budget, as a part of the national health mission in India. This offered half a billion poor Indians free access to health care. Also, the Indian government introduced National Health Protection Scheme (known as 'modicare') for 100 million poor families with the intention of making the healthcare system accessible. However,

all these schemes are in its budding stages and political controversies are existing regarding the implementation these schemes.

But, all those above mentioned schemes are mainly introduced for the poor people in India. So, there is a huge urge from the middle class society (they represent the major population in India) in India to introduce beneficial health care schemes that ensure the easily accessible health care system for them

### **General implications**

Quality training and education sessions for the therapist that focus on promoting and enhancing the patient-therapist interaction is highly recommended. The training and education sessions that improve therapist's awareness about how contextual factors influence the physiotherapist's position of power and the interactional strategies that enable them to manage their power while they interacting with the patient in different situations (Nimmon & Hayes, 2016). The training provides opportunities to the therapist to be reflexive about their power and how it plays out in different interaction is recommended (Nimmon & Hayes, 2016).

It is recommended to provide more emphasis in the undergraduate curriculum about the importance of power sharing during the interaction, social exchange with patients and to acknowledge the involvement of non-medical contextual factors in patient's outcome. Physiotherapy colleges should increase the availability of continuous professional development opportunities by organising workshops, seminars and incorporating courses on outcome measures in their curriculum.

In table 9:1 summarise the significant points of implications, which is applicable to different layers (interaction, institutional and the wider societal aspect).

**Table 9.1 Summary of implications**

Implication at different layers	Main Implications
<b>Implications at Interactional level</b>	<ul style="list-style-type: none"> <li>• Addressing the patient according to their religious belief is one of the recommended strategies to improve therapeutic relationship.</li> <li>• While interacting with the patient, the therapist should be aware about the situation before using 'I language assertion'</li> <li>• Express alignment with each other's' views, and openness, reassuring the patient, patient illustration of desire to co-operate with the treatment and critical reflection by the patient about their previous unsuccessful choice of treatment strategy were identified as the interaction strategies that positively influence the therapeutic relationship.</li> <li>• Self-disclosure has a positive influence in creating a better therapeutic relationship. However, before deciding whether to reveal something about themselves, therapist must know their patients well</li> </ul>
<b>Implications at institutional contextual level</b>	<ul style="list-style-type: none"> <li>• According to this study encouraging patient autonomy and consideration of patient concerns in a patient centred way are the suggested method to ensure active patient participation in the healthcare interaction.</li> <li>• Diplomatic attitude can be suggested to the physiotherapist to use as a cognitive method to illustrate a mutual respect. According to this study diplomatic attitude can be suggested</li> </ul>

	<p>to the physiotherapists who handle the situation in which the patient has a different opinion from the doctor who referred the patient to physiotherapy.</p> <ul style="list-style-type: none"> <li>• Interpersonal communication skills, including empathy and negotiations are factors that are recommended by this study to enhance the mutual therapeutic relationship.</li> <li>• The government can contribute to the issues related to patient's affordability and accessibility to physiotherapy treatment, which in turn was identified as an influence on patient compliance and the therapeutic relationship.</li> <li>• Consider patient expectation, provide the available treatment options to the patient according to their expectation is a recommended method to enhance mutual therapeutic relationship</li> <li>• Introduction of patient-reported outcome measures is highly recommended in the Indian physiotherapy settings.</li> </ul>
<p><b>Implications for wider societal aspect</b></p>	<ul style="list-style-type: none"> <li>• Quality training sessions on communication skills are suggested for Indian therapists to handle the challenges that they face when communicating with patients of a different age group and gender.</li> <li>• It is recommended to provide awareness and training programs program regarding the importance of power of knowledge (as an expert) and how it effectively implement while interacting with different patients in different situation.</li> <li>• It is recommended to provide more emphasis social exchange and the involvement of non-medical contextual factors in patient's outcome.</li> </ul>

### Future research

The attitude, belief, values and expectations of the patient that were recognised in the extracts of this study might be applicable in other settings outside of India. So further research is needed in this area.



This research is conducted in the physiotherapy context of Kerala. So, it is suggested to repeat this research in the context of different states in India, especially, in the context of North Indian states. This will help to generalise the findings. Also, will help to identify how the socio-cultural variability of different states in India affects the findings

Many of the extracts in this study identified that age was a factor that influenced the therapeutic relationship in Indian physiotherapy context. So further research is needed in this area. Further work is needed to find out the successful interaction strategy to handle patient concerns that could originate from incongruence between patient expectation and therapist perception about the recovery.

#### **9:6. Strength of the study**

This study provides a unique contribution to knowledge by being the first critical realist ethnography study exploring the therapeutic relationship in the context of Indian physiotherapy. This study is considered as one of a limited number of studies in global physiotherapy research that utilized the elements of Fairclough's discourse analysis and the first study that used the element of Fairclough's discourse analysis in the Indian physiotherapy setting.

The thoughts from different disciplines involved in this study was considered an added strength of this study. Especially, the use of discourse analytical concepts to find the objectives of this study, which are based on the field of physiotherapy as identified as a strength of this research. Multiple perspectives of interpretation using a single set of data were done throughout the analysis and discussion stages. For instance, interpretation of data in its societal, medical and

interactional level was helped to identify the different dimensions of the single process using a single set of data.

The three supervisors involved in this study were from the UK and myself from India. So, all of those supervisors from the western socio-cultural background, supervised this study and were regularly involved in the discussion of the data analysis. So, our different cultural background in those discussions helped and supported very much in balancing in terms of the outsider and insider and outsiders perspective throughout the analysis.

## **9: 7. Limitations of the study**

One of the limitations of this study is non-verbal communication was not adequately included in the selected extracts. Many other features of the conversations e.g. glances, shifting of posture, etc. were missed in this study. This will limit the detailed analyses. However, certain non-verbal features were brought to the data with the help of field notes.

Lack of experience of the researcher in the area of linguistics could have affected the linguistic aspects of the analysis. In this study, the linguistic aspect of the conversation was not considered indepthly. However, it should be noted that one of the aims of this study was to identify the interactional features of the therapeutic relationship, not the typical linguistic aspects.

The findings of this study are difficult to generalize in terms of the wider population because this study collected the data only from the three out-patient physiotherapy units from the state of Kerala. However, it should be noted that it was not the intention of the current study to generalize the findings to a wider

population, as the main aim was to identify the interactional features, contextual factors and power dynamics in Indian outpatient physiotherapy settings. Therefore, theoretically, it is possible to argue that the results of the current study are applicable to the subjects with the same or similar characteristic with that of the participants included in the study.

## **9: 8 Thesis conclusion**

This thesis provides a unique contribution to knowledge about the therapeutic relationship in South Indian outpatient physiotherapy settings. It offers an understanding of interactional features, institutional and societal level contextual factors, and the involved power influences in the formation of a better therapeutic relationship in the context of south Indian out-patient physiotherapy settings. In addition to that, this study describes how the patient's compliance, the element of solidarity and patient's expectations were closely linked with the therapeutic relationship. Alignment with each other's' views, reassuring patients, openness, patient's turn taking and critical reflection from the patient's side are the interactional features that were considered by this study to create a better therapeutic relationship. Patient resistance to treatment, contradictory beliefs of patient and therapist, non-alignment with patient's perspective are the interactional features that recognised as negatively influence the therapeutic relationship. Also, certain convincing strategies include mention higher authority, I- language assertion and persuasion used by the therapist to handle the patient concerns, demand and compliance are identified as negatively influence the therapeutic relationship. However, certain interactional strategies influence ambivalently in the formation of therapeutic relationship; for example, therapist's assertion.

The interpersonal communication skills of the therapist such as empathy, negotiation; certain attitudes of the therapist such as diplomatic attitude, encourage patient autonomy; patient's self-motivation, symptom tolerance, trust and believes are institutional factors that were considered positively influence in creating the therapeutic relationship. According to the analysed situations in this study patient less pain tolerance, affordability, accessibility, miscommunication or lack of communication between patient and therapist are the factors that influence the therapeutic relationship in a negative manner. But, certain institutional contextual factors influence ambivalently in creating the better therapeutic relationship; for instance, therapist role of an expert. Age, gender, religion, mutuality, paternalism and consumerism are the identified societal level factors that influence the formation of the therapeutic relationship.

This study suggests the patient rated outcome measure as a contextual element to build up mutuality in patient-therapist relationship in the Indian context. Considering the patient expectation is important before referring the patient to physiotherapy treatment by the doctor, and before providing physiotherapy treatment.

This study explored how the therapists handle the patients with similar or opposing ideological belief to the philosophy behind the physiotherapy; and how the way of handling influence to the formation of therapeutic relationship contextually. This study also discussed the strategies that Indian physiotherapist used to express solidarity to create a mutual therapeutic relationship. The three therapeutic relationship models that constructed from this study were identified as the discrete representation of the therapeutic relationship. These models will help the therapist to acknowledge the importance to share the power in communication using different interactional strategies and the contextual factors

involved in the formation a better therapeutic relationship. Mutual therapeutic relationship model is considered as the ultimate model that enhances the therapeutic relationship. However, the paternalistic model, as well as the consumerist approach were used in the therapeutic relationship, indicating that power imbalances in the patient-therapist relationship are negotiable and subject to change.

This is considered one of the first studies in physiotherapy research that utilized the elements of Fairclough's discourse analysis. So, it enables the global physiotherapist to know about the scope of Fairclough's discourse analysis and it will add different methodological dimension in the field of physiotherapy research by drawing on theories and approaches from a range of disciplines, typically from outside medicine. This study based on critical realist perspective allows the abductive style of data analysis. So that, this research did not provide any definitive conclusion about the identified findings. However, the findings identified are considered as the possible factors that can influence the therapeutic relationship. Ethnography stands as the methodological framework in this study, which allowed the researcher to collect the data that is considered close to the nature of reality.

This study enable the physiotherapist in Kerala to think further about the relevance of non-medical factors and its associated elements in their day-to-day physiotherapy practice This study acknowledges and provides an insight to the global physiotherapist to think further about the important role of the power discourse and the social exchange happening between the therapist and patient in different aspects of the therapeutic process. The attitude, belief, values and expectations of the patient that were recognised in the extracts of this study might be applicable in other settings outside of India.

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## APPENDICES

### Appendix 1: Ethical approval was gained from Sheffield Hallam University

#### Ethics committee.



Date 19062015

Research proposal number: 2014-5/HWB-HSC-31

Dear Soumya CHETTYAR

This letter relates to your research proposal:

Patient-therapist relationship in physiotherapy setting in India

This proposal was submitted to the Faculty Research Ethics Committee with a standard SHREC1 form. It has been added to the register of projects and given a reference number. You will need to ensure you have all other necessary permission in place before proceeding, for example, from the Research Governance office of any sites outside the University where your research will take place. This letter can be used as evidence that the proposal has ethical approval from Sheffield Hallam University.

The documents reviewed were:

CHETTYARBinder1.pdf

Good luck with your project.

Yours sincerely

A handwritten signature in black ink that reads 'Peter Allmark'.

Peter Allmark  
Chair Faculty Research Ethics Committee  
Faculty of Health and Wellbeing  
Sheffield Hallam University  
32 Collegiate Crescent  
Sheffield  
S10 2BP  
0114 224 5727  
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Faculty of Health and Wellbeing | Montgomery House | 32 Collegiate Crescent | Sheffield | S10 2BP | UK  
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## Appendix 2: Ethical approval was gained from Medical Trust Hospital.



M.G. Road,  
COCHIN - 682 016  
PAN: AABCP3848D

Tel : 0484-2358001-11  
Fax : 0484-2358031  
Service Tax No. AABCP3848DSD001

E-Mail : [info@medicaltrushospital.org](mailto:info@medicaltrushospital.org)  
Website : [www.medicaltrushospital.com](http://www.medicaltrushospital.com)



**M E D I C A L T R U S T H O S P I T A L**

(Owned by Pulikkal Medical Foundation)

06-07-2015.

### TO WHOMSOEVER IT MAY CONCERN

Research Title: Patient Therapist relationship in Physiotherapy Settings in India.

Researcher: Soumya Shanmughan Chettyar, Sheffield Hallam University

This is an official ethical approval letter for Mrs Soumya Shanmughan Chettyar, Centre for Health and Social Care Research, Colligate Crescent, Sheffield Hallam University to conduct her research in physiotherapy outpatient department of Medical Trust Hospital from 08 July 2015 to 31 August 2015.

Dr. P. V. THOMAS  
MANAGING DIRECTOR

### Appendix 3: Ethical approval was gained from Medical college Hospital (2015, First stage data collection)

#### **PROCESSINGS OF THE PRINCIPAL, GOVERNMENT MEDICAL COLLEGE THIRUVANANTHAPURAM**

Government Medical College, Thiruvananthapuram-General-Permission to Collect Data from PMR Detachment-Granted- orders issued.

Read: 1. Request dated: 10-07-2015 received from Smt. Soumya Shanmughan Chettyar  
2. Remarks received from Head of the Department, PMR.

#### **ORDER NO.G1/480282015/MCT,DATED:27/07/2015**

Smt. Soumya Shanmughan Chettyar, Centre for Health and Social Care Research, Collegiate Crescent, Sheffield, South Yorkshire, England has requested to grant permission to do data collection in the Department of PMR from 17/08/2015 to 17/09/2015. The Professor and Head of Department of the PMR had recommended to the same.

In the circumstances permission is granted to Smt. Soumya Shanmughan Chettyar to do the data collection from 17/08/2015 to 17/09/2015 in the above Department subject to the following condition

1. Candidate should remit an amount of Rs.500/- (Rupees five hundred only) at the cash counter of the principal's office before starting the data collection.
2. The candidate should submit all original certificate to the professor and Head of Department of PMR with direction to verify the genuinely of the certificate processed by the candidate
3. The data collection does not affect the normal functioning of the department and does not misuse any data collected from the college.
4. She will not handover the photos, videos or recorded voice to any media.
5. She will not publish any comparative study with other centres on India or abroad.
6. She is not eligible for any kind of stipend during the data collection period.
7. The candidate will be under the strict disciplinary control of the Head of the Department concerns.

Sd/  
Dr. Thomas Mathew  
PRINCIPAL

To:  
The incumbent concerned.

Copy to:

1. The Superintendent, MCH, Thiruvananthapuram
2. The Professor and Head of the Department of PMR,
3. The cash section, MCH
4. Stock file/Office copy

**FORWARDED/BY ORDER**



**JUNIOR SUPERINTENDENT**

**Appendix 4: Ethical approval was gained from Medical college Hospital (2016, second stage data collection).**

**PROCEEDINGS OF THE VICE-PRINCIPAL, GOVERNMENT MEDICAL COLLEGE  
THIRUVANANTHAPURAM**

Sub:- Govt. Medical College Thiruvananthapuram-Academic-Permission to undergo two months data collection in the department of P M R GMCT to Smt. Soumya Shanmughan Chettyar- Permission granted - orders issued

Read: 1. Request dated 11/07/2016 from Smt, Soumya Shanmughan Chettyar Nedyvilaveedu, Vanchiyoor. P.O. Attingal, Thiruvananthapuram.

**ORDER NO. B5/23630/2016/GMCT DATED 01/08/2016**

Smt, Soumya Shanmughan Chettyar, P.H.D student from Sheffield Hallam University, South Yorkshire, England, vid her representations referred to above has requested to grant permission to collect interview data for a period of two months in the physiotherapy section work under the P M R department Thiruvananthapuram. The department of P M R has given no objection for this data collection and permitted for Smt, Soumya Shanmughan Chettyar to collect the data for her research purpose, w.e.f. 01/08/2016

In this circumstances permission is granted to Smt, Soumya Shanmughan Chettyar for two months to collect data at PMR department of this college w.e.f.01/08/2016 subject to following condition.

1. The amount of Rs-500/- (Rs- five hundred only) should be remitted in the cash counter of this college towards the fee for data collection. RS 500/-p.m.
2. The researcher should strictly follow the rules and regulations of this college and the instruction of the Head of the Department.
3. The collection of interviews should not hinder the normal function of this institution
4. The researcher trainees are liable to pay for any damage caused by them during the data collection period.
5. The process will not confer any right to the applicant for any kind of preference in job temporarily/permanently or higher studies in Medical College, Thiruvananthapuram.
6. The process will be under the strict disciplinary control of Head of the Department concern and the administrative control of the Principal, GMCT.
7. The candidate should submit the original certificate which enable her for collect the data to the professor and Head of the department of P M R for the verification.

Sd/-

Dr. K. Girijakumari  
VICE PRINCIPAL

To,  
Smt, Soumya Shanmughan Chettyar,  
Nedyvilaveedu, Vanchiyoor P.O  
Attingal, Thiruvananthapuram

Copy to:

1. The professor and Head of the Department PMR Government Medical College, TVM
2. The Superintendent GMCT
3. Cash Section GMCT
4. Office copy/ Stock file

FORWARDED/BY ORDER

  
SENIOR SUPERINTENDENT

## Appendix 5: Ethical approval was gained from Cosmopolitan Hospital



R/ADMIN-08/0

### COSMOPOLITAN HOSPITALS (P) LTD.

PATTOM , THIRUVANANTHAPURAM - 695 004

Phone : 91- 471- 2521252 (20 Lines), Fax : 91- 471- 2449188

CIN-U85110KL1979PTCOO3092

13-7-2016

Mrs Soumya Shanmughan Chettyar  
Sheffield Hallam University

Research title:

Patient therapist relationship in physiotherapy settings in India

Submitted by:

The Researcher: Mrs. Soumya Shanmughan Chettyar, Sheffield Hallam University

Mrs Soumya Shanmughan Chettyar, Centre for Health and Social Care Research , Collegiate crescent, Sheffield Hallam University, England has requested to grant permission to collect data from the outpatient physiotherapy department of Cosmopolitan Hospitals (P) Ltd, Thiruvananthapuram from 13/ 07/2016 to 20/08 2016. Cosmopolitan Hospitals (P) Ltd and Head of the physiotherapy department agreed to proceed her with data collection from 13/07/2016 to 20/08/2016. This is an official approval letter for her to collect the data from the above mentioned department of the Cosmopolitan Hospital.

For Cosmopolitan Hospitals (P) Ltd

  
N.K. Subash

General Manager (Administration)



email : cosmopolitan@cosmopolitanhospitals.in, www.cosmopolitanhospitals.in

## **Appendix 6: sample information sheet for therapist/ student therapist**

### **Information sheet for Therapist /Student therapist**

**Title of Project:** Patient-therapist relationship in physiotherapy settings in India.

#### **What is the aim of the study?**

Aim of this study is to investigate the intangible elements that underpinning the patient therapist relationship in the socio-cultural and clinical context of the Indian outpatient physiotherapy settings in India.

#### **What are the Objectives of the study?**

- To identify the involvement of power in patient-therapist relationships in an Indian outpatient physiotherapy setting.
- To understand the patient-therapist interactional strategies and how it influence in creating therapeutic relationship in an Indian outpatient physiotherapy settings.
- To identify the institutional and societal contextual elements that are associated with the therapeutic-relationship in an Indian outpatient physiotherapy setting.

#### **Who can participate in the study?**

All the physiotherapist and currently practising in the physiotherapy outpatient setting in Medical College Hospital or student therapist in their period of internship after completing the bachelors degree currently receiving clinical experiences in the physiotherapy setting of Medical College Hospital can take part in this study, if provide consent to participate.

#### **What will I be required to do?**

If you attend the outpatient physiotherapy department for assessing or treating patients and you are interested to take part in the study then you can agree to the researcher observing the consultation session with your patient (If they give their consent).

#### **What will happen during observation?**

The researcher will observe and audio-record the therapeutic session. That means the researcher will not be involved in giving clinical care or looking at the patient's medical records. The researcher will be sitting in the room observe, record the interaction using an audio recorder and will take written notes. After the treatment session the researcher may be ask some questions related to what she observed during the treatment session to clarify the doubts.

#### **Who will be responsible for all of the information when this study is over?**

The primary researcher will be responsible for all the information that is collected for the entire research



**What will do with the collected data (both the written notes and recorded conversation)?****Who will have access to it?**

All the documents will be kept in a secure place, to which only the researcher will have access. The reports and publications arising from the study will not identify any individual who participated. I will use some short extracts from the transcripts in my research project and in future publications, but these will be kept anonymous.

**What will happen to the information when this study is over?**

All the information will be kept confidentially for up to seven years. It will not be handed over to other people and not used for other studies

**How will the information be used?**

It is hoped that the research findings will be disseminated through conference presentations and publications in both India and UK. The doctoral thesis arising from my research will be available via the Sheffield Hallam University and British library.

**Will anyone be able to connect me with what is recorded and reported?**

No. The research findings will not disclose the actual name of the participants. Coded numbers or letters will used to denote the participants throughout the study.

**How long is the whole study likely to last?**

The entire study will last four years.

**How can I find out about the results of the study?**

The doctoral thesis arising from my research will be available via the British library and the University of Sheffield library.

**What if I do not wish to take part?**

Your participation is entirely voluntary; it is up to you to decide whether or not to take part.

**What if I change my mind during the study?**

It is necessary to know that even though you agree to take part in the study and you give consent, you still have the right to withdraw at any time and without giving reasons and that will not affect the standard of care or any treatment you receive.

**Do you have any other questions?****Please contact:**

<b>Name</b>	<b>Soumya Shanmughan Chettyar</b>	<b>Dr Stephen May</b>	<b>Dr Kate Grafton</b>
<b>Role</b>	PhD researcher	Director of Studies	Supervisor
<b>Email</b>	Soumya.ShanmughanChettyar@student.shu.ac.uk	s.may@shu.ac.uk	k.grafton@shu.ac.uk
<b>Telephone</b>	9526415457	+4401142252370	-
<b>Address</b>	Soumya Shanmughan Chettyar, Nediavila Veedu, Vanchiyoor P.O Attingal, Thiruvananthapuram.	Dr Stephen May 38 Collegiate Crescent,	Dr Kate Grafton Collegiate Crescent, Sheffield

		Sheffield Hallam University Sheffield, South Yorkshire S10 2BP.	Hallam University Sheffield, South Yorkshire S10 2BP.
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**Details of who to contact with any concerns or if adverse effects occur after the study.**

- 1) Peter Allmark  
Chair Faculty Research Ethics Committee  
Faculty of Health and Well being  
Sheffield Hallam University  
32 Collegiate crescents  
Sheffield, South Yorkshire, UK  
S10 2BP.
  
- 2) Dr Stephen May  
38 collegiate Crescent, Sheffield Hallam University  
Sheffield, South Yorkshire  
S10 2BP.

## **Appendix7: sample information sheet for patient**

### **Information sheet for Patient**

**Title of Project:** Patient-therapist relationship in physiotherapy settings in India.

#### **What is the aim of the study?**

Aim of this study is to investigate the intangible elements that underpinning the patient therapist relationship in the socio-cultural and clinical context of the outpatient physiotherapy settings in India.

#### **What are the Objectives of the study?**

- To identify the involvement of power in patient-therapist relationships in an Indian outpatient physiotherapy setting.
- To understand the patient-therapist interactional strategies and how it influence in creating therapeutic relationship in an Indian outpatient physiotherapy settings.
- To identify the institutional and societal contextual elements that are associated with the therapeutic-relationship in an Indian outpatient physiotherapy setting.

#### **Who can participate in the study?**

All the patients above 18 years of age who visit the physiotherapy outpatient department of Thiruvananthapuram Cosmopolitan Hospital can take part in this study, if provide consent to participate.

#### **What will I be required to do?**

If you attend the outpatient physiotherapy department for treatment and you are interested to take part in the study then you can agree to the researcher to interview (If you give your consent).

#### **What will happen during Interview? How often will I have to take part, and for how long?**

The interview will usually be based on what happened during the consultation. The interview will be tape recorded with your agreement. You will be interviewed by the researcher alone once and the interview will take approximately 20 to 30 minutes.

#### **Where will the interview take place?**

Once you agree to participate in the interview the interview will be conducted at hospital at any time after the consultation. However, if you or the researcher are not able to perform the interview on the same date that you previously agree with the researcher, an appointment will be arranged to conduct the interview at a convenient day/time in the hospital.

#### **Who will be responsible for all of the information when this study is over?**

The primary researcher will be responsible for all the information that is collected for the entire research

#### **What will do with the collected data (both the written notes and recorded conversation)?**

#### **Who will have access to it?**

All the documents will be kept in a secure place, to which only the researcher will have access. The reports and publications arising from the study will not identify any individual

who participated. I will use some short extracts from the transcripts in my research project and in future publications, but these will be kept anonymous.

**What will happen to the information when this study is over?**

All the information will be kept confidentially for up to seven years. It will not be handed over to other people and not used for other studies

**How will the information be used?**

It is hoped that the findings will be disseminated through the conference presentations and publications in both India and UK. The doctoral thesis arising from my research will be available via the Sheffield Hallam University and British library.

**Will anyone be able to connect me with what is recorded and reported?**

No. The research findings will not disclose the actual name of the participants. Coded numbers or letters will used to denote the participants throughout the study.

**How long is the whole study likely to last?**

The entire study will last four years.

**How can I find out about the results of the study?**

The doctoral thesis arising from my research will be available via the British library and the University of Sheffield library

**What if I do not wish to take part?**

Your participation is entirely voluntary; it is up to you to decide whether or not to take part.

**What if I change my mind during the study?**

It is necessary to know that even though you agree to take part in the study and you give consent, you still have the right to withdraw at any time and without giving reasons and that will not affect the standard of care or any treatment you receive.

**Do you have any other questions?**

**Please contact:**

<b>Name</b>	<b>Soumya Shanmughan Chettyar</b>	<b>Dr Stephen May</b>	<b>Dr Kate Grafton</b>
<b>Role</b>	PhD researcher	Director of Studies	Supervisor
<b>Email</b>	Soumya.ShanmughanChettyar@student.shu.ac.uk	s.may@shu.ac.uk	k.grafton@shu.ac.uk
<b>Telephone</b>	9526415457	+4401142252370	-
<b>Address</b>	Soumya Shanmughan Chettyar, Nediya Vila Veedu, Vanchiyoor P.O Attingal, Thiruvananthapuram.	Dr Stephen May 38 Collegiate Crescent, Sheffield Hallam University Sheffield, South Yorkshire S10 2BP.	Dr Kate Grafton Collegiate Crescent, Sheffield Hallam University Sheffield, South Yorkshire S10 2BP.

**Details of who to contact with any concerns or if adverse effects occur after the study.**

**1) Peter Allmark**

Chair Faculty Research Ethics Committee  
Faculty of Health and Well being  
Sheffield Hallam University  
32 Collegiate crescent  
Sheffield, South Yorkshire, UK  
S10 2BP.

**2)Dr Stephen May**

Sheffield Hallam University  
38 collegiate Crescent, Sheffield, South Yorkshire  
S10 2BP.

## Appendix 8: Consent form used for both patient and therapist

### Sample participant consent form

**Title of research study:** Patient-therapist relationship in physiotherapy settings in India

*Please answer the following questions by ticking the response that applies*

	YES	NO
I have read the Information Sheet for this study and have had details of the study explained to me.	<input type="checkbox"/>	<input type="checkbox"/>
My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any point.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I am free to withdraw from the study within the time limits outlined in the Information Sheet, without giving a reason for my withdrawal or to decline to answer any particular questions in the study without any consequences to my future treatment by the researcher.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to provide information to the researchers under the conditions of confidentiality set out in the Information Sheet.	<input type="checkbox"/>	<input type="checkbox"/>
I wish to participate in the study under the conditions set out in the Information Sheet.	<input type="checkbox"/>	<input type="checkbox"/>
I consent to the information collected for the purposes of this research study, once anonymised (so that I cannot be identified), to be used for any other research purposes.	<input type="checkbox"/>	<input type="checkbox"/>

**Participant's Signature:**

**Date:**

**Participant's Name:**

**Contact details:**

**Researcher's Name:** Soumya Shanmughan Chettyar

**Researcher's Signature:** 

**Researcher's contact details:**

Address: Soumya Shanmughan Chettyar, Centre for Health and Social Research, Collegiate Crescent, Sheffield, South Yorkshire S10 2BP  
Email: Soumya.ShanmughanChettyar@student.shu.ac.uk

**Appendix: 9 Sample Patient Information Sheet in Malayalam**

**ഗവേഷണത്തെക്കുറിച്ചുള്ള വിവരണം**

- എന്താണ് ഗവേഷണത്തിന്റെ തലക്കെട്ട്?

ഇന്ത്യൻ ഫിസിയോതെറാപ്പി മേഖലയിൽ രോഗിയും തൊഴിലുറക്കും തമ്മിലുള്ള ബന്ധം.

- എന്താണ് ഗവേഷണത്തിന്റെ ലക്ഷ്യം?

മേൽപറഞ്ഞ ഗവേഷണത്തിന്റെ ലക്ഷ്യമെന്തെന്നാൽ ഇന്ത്യയിലെ ഔട്ട്പേഷ്യന്റ് ഫിസിയോതെറാപ്പി ചികിത്സാലയത്തിന്റെ ഭാഗമായിട്ടുള്ള ഫിസിയോതെറാപ്പിസ്റ്റും പേഷ്യന്റും തമ്മിലുള്ള ബന്ധത്തിന്റെ സാമൂഹികവും സാംസ്കാരികവുമായ ഘടകങ്ങൾ സൂക്ഷ്മമായി പരിശോധിക്കുക എന്നതാണ്.

- എന്താണ് ഗവേഷണത്തിന്റെ വസ്തുതാനിഷ്ടമായ അവലോകനം?

- ഫിസിയോതെറാപ്പിസ്റ്റും രോഗിയുമായുള്ള ബന്ധത്തെക്കുറിച്ച് പഠിക്കുക
- ഫിസിയോതെറാപ്പിസ്റ്റും രോഗിയുമായുള്ള ബന്ധത്തിൽ സാമൂഹികവും സാംസ്കാരികവുമായുള്ള ഘടകങ്ങളുടെ പ്രാധാന്യം മനസ്സിലാക്കുക
- ഫിസിയോതെറാപ്പിസ്റ്റും രോഗിയുമായുള്ള ബന്ധത്തെക്കുറിച്ച് ഇന്ത്യൻ ഔട്ട്പേഷ്യന്റ് ഫിസിയോതെറാപ്പി ചികിത്സാലയത്തിൽ സേവനമനുഷ്ഠിക്കുന്ന ഫിസിയോതെറാപ്പിസ്റ്റിന്റെ കാഴ്ചപ്പാട് മനസ്സിലാക്കുക.
- ഫിസിയോതെറാപ്പിസ്റ്റും രോഗിയുമായുള്ള ബന്ധത്തെക്കുറിച്ച് ഇന്ത്യൻ ഔട്ട്പേഷ്യന്റ് ഫിസിയോതെറാപ്പി ചികിത്സാലയത്തിൽ നിന്ന് ഫിസിയോതെറാപ്പി ചികിത്സ സ്വീകരിച്ചതോ സ്വീകരിച്ചുകൊണ്ടിരിക്കുന്നതോ ആയ രോഗിയുടെ കാഴ്ചപ്പാട് മനസ്സിലാക്കുക.

- മേൽപറഞ്ഞ ഗവേഷണത്തിൽ പങ്കെടുക്കാൻ പറ്റുന്നവർ ആരൊക്കെയാണ്?

ഗവേഷണത്തിൽ പങ്കെടുക്കാൻ അനുമതി ഒപ്പിട്ടു നൽകുന്ന പതിനെട്ടുവയസ്സിനു മുകളിലുള്ള എല്ലാ ഫിസിയോതെറാപ്പിരോഗികൾക്കും ഇതിൽ പങ്കെടുക്കാവുന്നതാണ്. .

- എന്താണ് നിങ്ങൾ ചെയ്യേണ്ടത്?

നിങ്ങൾ മെഡിക്കൽ കോളേജ് ഹോസ്പിറ്റലിൽ ഫിസിയോതെറാപ്പി ഒ.പി വിഭാഗത്തിൽ നിന്നും ചികിത്സ തേടുന്നതും മേൽപറഞ്ഞ ഗവേഷണത്തിൽ പങ്കെടുക്കുവാൻ താൽപര്യമുള്ള തുടയ വ്യക്തിയാണെങ്കിൽ നിങ്ങൾക്ക് ഗവേഷകയുമുള്ള ഇൻ്റർവ്യൂവിന് സമ്മതമാണെന്ന പത്രിക ഒപ്പിട്ടു നൽകാവുന്നതാണ്.

- എന്താണ് ഇൻ്റർവ്യൂ സമയത്ത് സംഭവിക്കുന്നത്? എത്ര പ്രാവശ്യം ആണ് ഇൻ്റർവ്യൂ ചെയ്യപ്പെടുന്നത് ? എത്ര സമയം ഇൻ്റർവ്യൂ ചെയ്യും?

ഫിസിയോതെറാപ്പി ചികിത്സയുമായി ബന്ധപ്പെട്ടുള്ള ചോദ്യങ്ങളാണ് ഇൻ്റർവ്യൂ സമയത്ത് ചോദിക്കുന്നത്. നിങ്ങളുടെ സമ്മതപ്രകാരം ഇൻ്റർവ്യൂ ട്രൈപ്പിക്ലോർഡ് ചെയ്യപ്പെടും ഒരു

പ്രാവശ്യത്തിൽകൂടുതൽ ഇന്റർവ്യൂ ചെയ്യപ്പെടുകയില്ല. ഏകദേശം 20 മിനിറ്റുമാത്രം 30 മിനിറ്റുവരെ ഇന്റർവ്യൂ ചെയ്യപ്പെടാം.

- എവിടെയാണ് ഇന്റർവ്യൂ നടക്കുന്നത്

ഇന്റർവ്യൂവിൽ പങ്കെടുക്കുവാനുള്ള സമ്മതം കൊടുത്തുകഴിഞ്ഞാൽ ഏത് സമയത്തും അശുപ്രത്യക്ഷതയിൽ വെച്ച് ഇന്റർവ്യൂ ചെയ്യപ്പെടാവുന്നതാണ് . അത് നിങ്ങൾക്കും ഗവേഷകയ്ക്കും സൗകര്യപ്രദമായ സമയത്തും സ്ഥലത്തും ആശുപത്രിയിൽ വെച്ചുകൊണ്ട് നടക്കുന്നത്. ഇന്റർവ്യൂ നിശ്ചയിച്ച ദിവസത്തിനോ സമയത്തിനോ ഏതെങ്കിലും വിധത്തിൽ അസൗകര്യം ഉണ്ടായാൽ റിസർച്ചറിന്റെ സമ്മതപ്രകാരം ഇന്റർവ്യൂ ഇരുവർക്കും സൗകര്യപ്രദമായ സമയത്തും ദിവസത്തിനും അശുപ്രത്യക്ഷതയിൽ വെച്ച് നടത്തുന്നതാണ്.

- ആരാണ് ഗവേഷണവുമായ ബന്ധപ്പെട്ട് ശേഖരിക്കുന്ന വിവരങ്ങളുടെ ഉത്തരവാദിത്വമുള്ള വ്യക്തി?

പ്രഥമ ഗവേഷകയ്ക്കാണ് ഗവേഷണവുമായ ബന്ധപ്പെട്ട് ശേഖരിക്കുന്ന വിവരങ്ങളുടെ ഉത്തരവാദിത്വം ഉള്ളത്.

- ശേഖരിച്ച വിവരങ്ങൾ പിന്നീട് എന്തുചെയ്യും? ആർക്കൊക്കെയാണ് വിവരങ്ങൾ ലഭിക്കുന്നത്?

ശേഖരിച്ച എല്ലാവിധമായ വിവരങ്ങളും പ്രാഥമിക ഗവേഷകയ്ക്കു മാത്രം അറിവുള്ളതായ സുരക്ഷിതമായ സ്ഥലത്ത് സൂക്ഷിക്കുന്നതായിരിക്കും. ശേഖരിച്ച വിവരങ്ങളുടെ അടിസ്ഥാനത്തിൽ നിന്നും രൂപപ്പെടുന്ന റിപ്പോർട്ടുകളിലോ പ്രസിദ്ധീകരണങ്ങളിലോ ഗവേഷണത്തിൽ പങ്കെടുത്ത വ്യക്തികളുടെ പേരോ, മറ്റു വ്യക്തി പരമായ വിവരങ്ങളോ ഉൾപ്പെടുത്തുന്നതല്ല. ശേഖരിച്ച വിവരങ്ങളിൽ നിന്നും ചില പ്രധാനപ്പെട്ട പകർപ്പുകൾ പ്രസിദ്ധീകരണങ്ങൾക്കു വേണ്ടി ഉപയോഗിക്കുമെങ്കിലും അവയിൽ യഥാർത്ഥമായ പേരുവിവരങ്ങൾ ഒന്നും തന്നെ ഉൾപ്പെടുത്തുന്നതല്ല..

- ഗവേഷണം പൂർത്തിയാകുമ്പോൾ ശേഖരിച്ച വിവരങ്ങൾക്ക് എന്തു സംഭവിക്കും?

ശേഖരിച്ച എല്ലാ വിവരങ്ങളും അതിസുരക്ഷിതമായി ഏഴു വർഷം വരെ സൂക്ഷിക്കും. വിവരങ്ങൾ മറ്റൊരാൾക്ക് കൈമാറുകയോ മറ്റൊരു ഗവേഷണത്തിനായി ഭാവിയിൽ ഉപയോഗിക്കുകയോ ചെയ്യുന്നതല്ല.

- ഗവേഷണത്തിനുവേണ്ടി ശേഖരിച്ച വിവരങ്ങൾ എങ്ങനെയാക്കെയാണ് ഉപയോഗിക്കുന്നത്?

ശേഖരിച്ച വിവരങ്ങളുടെ അടിസ്ഥാനത്തിൽ രൂപപ്പെടുന്ന ഫലം ഇന്ത്യൻ ഫിസിയോതെറാപ്പി മേഖലയിൽ സേവനമനുഷ്ഠിക്കുന്ന ഫിസിയോതെറാപ്പിസ്റ്റുകളുടെ ഇടയിൽ പ്രചരിപ്പിക്കുവാൻ ശ്രമിക്കും. അതുകൂടാതെ ഇന്ത്യയിലും യൂണൈറ്റഡ് കിങ്ഡമിലും പ്രസിദ്ധീകരിക്കുന്ന ശാസ്ത്രീയമായ പ്രസിദ്ധീകരണങ്ങൾ മുഖാന്തരവും ശാസ്ത്രീയ സമ്മേളനങ്ങൾ മുഖാന്തരവും



വ്യാപിപ്പിക്കുവാനും കഴിയുമെന്ന് പ്രതീക്ഷിക്കുന്നു. അതുകൂടാതെ മേൽപറഞ്ഞ ഗവേഷണത്തിന്റെ ഫലമായ് രൂപപ്പെടുന്ന പ്രബന്ധം ഷെഫീൽഡ് ഹാലം യൂണിവേഴ്സിറ്റി ലൈബ്രറിയിലും ബ്രിട്ടീഷ് ലൈബ്രറിയിലും സൂക്ഷിക്കുകയും ചെയ്യും.

- ഗവേഷണത്തിന്റെ ഫലമായ് രൂപപ്പെടുന്ന റെക്കോർഡുകളിലോ, റിപ്പോർട്ടുകളിലോ പങ്കെടുത്ത വ്യക്തിയുമായ് ബന്ധപ്പെടുന്ന വിവരങ്ങൾ ആർക്കെങ്കിലും തിരിച്ചറിയാനാകുമോ?

ഇല്ല. പങ്കെടുത്ത വ്യക്തിയുടെ പേരുവിവരങ്ങളോ, പേരുമായ് ബന്ധപ്പെടുന്ന അക്ഷരങ്ങളോ, സൂചനങ്ങളോ ഗവേഷണത്തിനുമുന്നിലും ഉപയോഗിക്കുന്നതല്ല.

- എത്ര വർഷമാണ് മേൽപറഞ്ഞ ഗവേഷണത്തിന്റെ കാലയളവ്?  
മൂന്നുവർഷമാണ് ഗവേഷണം പൂർത്തിയാക്കാൻ എടുക്കുന്നത്.

- ഗവേഷണത്തിന്റെ ഫലം എങ്ങനെ ലഭ്യമാകുന്നു?

ഗവേഷണത്തിന്റെ ഫലമായ് രൂപപ്പെടുന്ന പ്രബന്ധം ഷെഫീൽഡ് ഹാലം യൂണിവേഴ്സിറ്റി ലൈബ്രറി വഴിയും ബ്രിട്ടീഷ് ലൈബ്രറി വഴിയും ലഭ്യമാകുന്നതാണ്.

- ഗവേഷണത്തിൽ പങ്കെടുക്കാൻ താൽപര്യമില്ലെങ്കിൽ എന്തു ചെയ്യും?  
ഗവേഷണത്തിൽ പങ്കെടുക്കുന്നത് സ്വന്തം ഇഷ്ടപ്രകാരം മാത്രമാണ്.

- ഗവേഷണത്തിൽ പങ്കെടുക്കുവാനുള്ള അനുമതി നൽകിയ ശേഷം വിപരീതമായ അഭിപ്രായമുണ്ടായാൽ എന്തുചെയ്യും?

ഗവേഷണത്തിൽ പങ്കെടുക്കുവാനുള്ള അനുമതി നൽകിയ ശേഷം ഗവേഷണത്തിൽ പങ്കെടുക്കുവാൻ താൽപര്യമില്ലെങ്കിൽ നിങ്ങൾക്ക് ഇതിൽ നിന്നും ഏതുസമയത്തും പിന്മാറാവുന്നതാണ്. അതിനുവേണ്ടി നിങ്ങൾ കാരണം കാണിക്കണമെന്നില്ല. നിങ്ങളുടെ പിന്മാറൽ നിങ്ങളുടെ ചികിത്സയെ ഒരു തരത്തിലും ബാധിക്കുന്നതല്ല.

- എന്തെങ്കിലും ചോദ്യമുണ്ടെങ്കിൽ ബന്ധപ്പെടേണ്ട വിവരം ചുവടെ ചേർക്കുന്നു.

1) സൗമ്യ ഷൺമുഖൻ ചെട്ടിയാർ

പി.എച്ച്.ഡി.റിസർച്ചർ

ഇ-മെയിൽ : Soumya.ShanmughanChettiyar@student.shu.ac.uk

Ph : 9526415457

വിലാസം : സൗമ്യ ഷൺമുഖൻ ചെട്ടിയാർ

നെടിയവിള വീട്, വഞ്ചിയൂർ പി.ഒ

ആറ്റിങ്ങൽ, തിരുവനന്തപുരം

2) ഡോ: സ്റ്റീഫൻ മേയ്  
ഡയറക്ടർ ഓഫ് സ്റ്റഡീസ്  
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വിലാസം : ഡോ: സ്റ്റീഫൻ മേയ്  
38 കോളി ഗെയ്റ്റ് ക്രസന്റ്  
ഷെഫീൽഡ് ഹാലം യൂണിവേഴ്സിറ്റി  
ഷെഫീൽഡ് , സൗത്ത് യോർക്ക് ഷെയർ  
യൂണൈറ്റഡ് കിങ്ഡം, S102BP

3) ഡോ: കേറ്റ് ഗ്രാഫ്റ്റർ  
സൂപ്പർ വൈസർ  
ഇ-മെയിൽ k.grafton@shu.ac.uk

വിലാസം : ഡോ: കേറ്റ് ഗ്രാഫ്റ്റർ  
കോളി ഗെയ്റ്റ് ക്രസന്റ്  
ഷെഫീൽഡ് ഹാലം യൂണിവേഴ്സിറ്റി  
ഷെഫീൽഡ് , സൗത്ത് യോർക്ക് ഷെയർ  
യൂണൈറ്റഡ് കിങ്ഡം, S102BP

- ഗവേഷണത്തിന്റെ ഭാഗമായി എന്തെങ്കിലും ദുഷ്യ ഫലമുണ്ടായാൽ ബന്ധപ്പെടേണ്ട വിലാസം ഏത്?

1) ഡോ: സ്റ്റീഫൻ മേയ്  
38 കോളി ഗെയ്റ്റ് ക്രസന്റ്  
ഷെഫീൽഡ് ഹാലം യൂണിവേഴ്സിറ്റി  
ഷെഫീൽഡ് , സൗത്ത് യോർക്ക് ഷെയർ  
യൂണൈറ്റഡ് കിങ്ഡം, S102BP

2) പീറ്റർ ആൾമാർക്ക്  
ചെയർ ഫാക്യൽറ്റി റിസർച്ച് എത്തിക്സ് കമ്മിറ്റി  
ഫാക്യൽറ്റി ഓഫ് ഹെൽത്ത് ആന്റ് വെൽബീയിംഗ്  
ഷെഫീൽഡ് ഹാലം യൂണിവേഴ്സിറ്റി  
ഷെഫീൽഡ് , സൗത്ത് യോർക്ക് ഷെയർ  
യൂണൈറ്റഡ് കിങ്ഡം, S102BP

**Appendix 10 Consent form in Malayalam**

**ഗവേഷണത്തിൽ പങ്കെടുക്കുവാനുള്ള സമ്മതപത്രം**

ഗവേഷണത്തിന്റെ തലക്കെട്ട് : ഇൻത്യൻ ഫിസിയോതെറാപ്പി മേഖലയിൽ രോഗിയും തെറാപ്പിസ്റ്റും തമ്മിലുള്ള ബന്ധം.

ചുവടെ കൊടുത്തിരിക്കുന്ന വാക്യങ്ങൾക്കു അനുയോജ്യമായ രീതിയിൽ 'ശരി' (✓) ചിഹ്നം ഉപയോഗിച്ച് നിങ്ങളുടെ അഭിപ്രായം പ്രകടിപ്പിക്കുക.

- |  | അതെ                      | അല്ല/ഇല്ല                |
|--|--------------------------|--------------------------|
| 1. ഗവേഷണവുമായി ബന്ധപ്പെട്ട വിവരങ്ങൾ അടങ്ങുന്ന പത്രിക വായിച്ചു മനസ്സിലാക്കുകയും ഗവേഷണവുമായി ബന്ധപ്പെട്ട വിവരങ്ങൾ ഗവേഷക എനിക്കു വിശദീകരിച്ചു തരുകയും ചെയ്തു.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ഗവേഷണവുമായി ബന്ധപ്പെട്ടുള്ള എന്റെ സംശയങ്ങൾക്കും തൃപ്തികരമായ രീതിയിൽ ഉത്തരങ്ങൾ ഗവേഷകയുടെ ഭാഗത്തു നിന്നു ലഭിക്കുകയും തുടർന്നുള്ള സംശയങ്ങൾ ഏതുസമയത്തും ഗവേഷക യോടു ചോദിച്ചു മനലിലാക്കാം എന്നും എനിക്ക് മനസ്സിലായി.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. ഗവേഷണവുമായി ബന്ധപ്പെട്ട വിവരങ്ങൾ അടങ്ങുന്ന പത്രികയിൽ രേഖപ്പെടുത്തിയിട്ടുള്ള സമയപരിധിക്കുള്ളിൽ നിന്നുകൊണ്ട് ഗവേഷണത്തിൽ നിന്നും കാരണമൊന്നും ബോധ്യപ്പെടുത്താതെ പിൻമാറുവാനുള്ള സ്വാതന്ത്ര്യം എനിക്ക് ഉണ്ടെന്നറിയാം അല്ലെങ്കിൽ ഗവേഷക ചോദിക്കുന്ന ചോദ്യങ്ങൾക്കു മറുപടി പറയാൻ താല്പര്യം ഇല്ലെങ്കിൽ അതിന് ഉത്തരം പറയാതിരിക്കുവാനുള്ള സ്വാതന്ത്ര്യം ഉണ്ടെന്നും എനിക്കു മനസ്സിലായി. മേൽ പറഞ്ഞ തീരുമാനങ്ങൾ ഒന്നും തന്നെ എന്റെ ചികിത്സയെയോ ചികിത്സയുമായി ബന്ധപ്പെട്ട കാര്യങ്ങളെയോ യാതൊരു വിധത്തിലും ബാധിക്കില്ലെന്നും എനിക്കു ബോധ്യം ഉണ്ട്. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. ഗവേഷണത്തിനെ കുറിച്ചുള്ള വിവരങ്ങൾ അടങ്ങുന്ന പത്രികകയിൽ പറഞ്ഞിട്ടുള്ള നിബന്ധനകൾ പ്രകാരം എന്റെ ചികിത്സയുമായി ബന്ധപ്പെട്ട സ്വാകാര്യമായ കാര്യങ്ങൾ ഗവേഷകയുമായി പങ്കു വയ്ക്കാൻ എനിക്കു സമ്മതമാണ്.  | <input type="checkbox"/> | <input type="checkbox"/> |

5. ഗവേഷണവുമായി ബന്ധപ്പെട്ട വിവരങ്ങൾ അടങ്ങുന്ന പത്രികയിൽ പറയുന്ന നിബന്ധനപ്രകാരം എനിക്കു ഗവേഷണത്തിൽ പങ്കെടുക്കാൻ ആഗ്രഹം ഉണ്ട്.

6. എന്റെ സമ്മതപത്രത്തോട് കൂടി ഞാൻ നൽകുന്ന വിവരങ്ങൾ അതിസുരക്ഷിതമായി സൂക്ഷിച്ചുവയ്ക്കുമെന്നും, അത് ഒരു കാരണ വശാലും വേറെ ഏതെങ്കിലും ഗവേഷണ ആവശ്യങ്ങൾക്കായി ഉപയോഗിക്കുന്നതല്ല എന്നും എനിക്ക് മനസ്സിലായി.

ഗവേഷണത്തിൽ പങ്കെടുക്കുന്ന ആളുടെ ഒപ്പ് : \_\_\_\_\_ തീയതി :

ഗവേഷണത്തിൽ പങ്കെടുക്കുന്ന ആളുടെ പേര് : \_\_\_\_\_

മേൽവിലാസം :

ഗവേഷകയുടെ പേര് : : \_\_\_\_\_

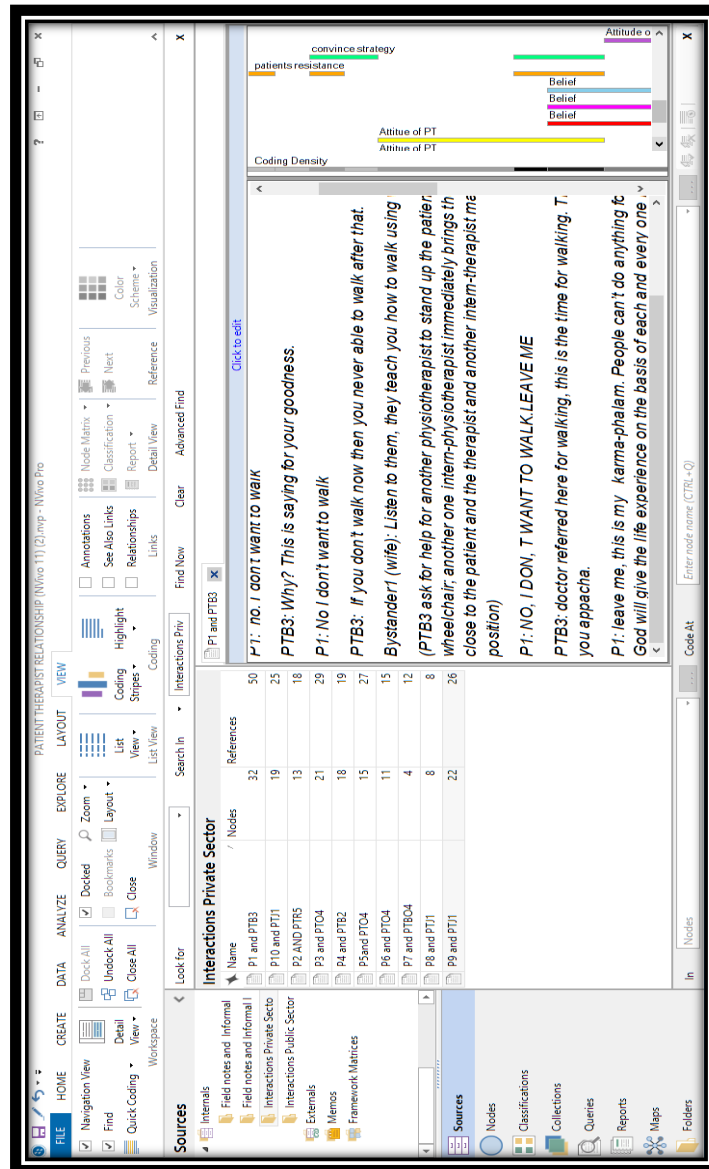
ഗവേഷകയുടെ ഒപ്പ് : : \_\_\_\_\_

ഗവേഷകയുടെ മേൽവിലാസം

സൗമ്യ ഷൺമുഖൻ ചെട്ടിയാർ  
 സെന്റർ ഫോർ ഹെൽത്ത് ആൻഡ്  
 സോഷ്യൽ കെയർ റിസർച്ച്  
 കോളിഗേയ്റ്റ് ക്രസന്റ്, ഷെഫീൽഡ് സൗത്ത് യോർക്ക് ഷെയർ  
 S102BP  
 ഇമെയിൽ : [Soumya.Shanmughanchettyar@student.shu.ac.uk](mailto:Soumya.Shanmughanchettyar@student.shu.ac.uk)

# Appendix11: Data analysis using Nvivo (First stage data collection)

## Screen short one: Data coding MTH



## Screen short Two: Data coding MCH

The screenshot displays the NVivo 11.2 software interface. The main window shows a list of nodes under 'Interactions Public Sector' with a table of references. The selected node, 'P13 & PTM9', is open in a text viewer showing several paragraphs of text. A 'Coding Density' bar chart is visible at the top of the text viewer, showing segments of text coded with different colors corresponding to categories like 'Attitude of PT' and 'Contextual factors'. The interface includes a top menu bar (FILE, HOME, CREATE, DATA, ANALYZE, QUERY, EXPLORE, LAYOUT, VIEW) and a left sidebar with 'Sources' and 'Interactions Public Sector'.

Name	Nodes	References
P11 & PTS10	23	23
P12 & PTM9	16	19
P13 & PTM9	12	12
P14 & PT S10	9	18
P15 & PTU8	15	19
P16 & PTM9	13	13
P17 & PTR6	4	4
P18 & PTS10	12	12
P19 & PTR7	4	4
P20 & PTR7	8	8

Text viewer content for 'P13 & PTM9':

PTM9: How is your pain?  
P13: Pain is not reduced  
PTM9: is not reduced? Did you do any heavy work using this hand?  
P13: hmmm.... I usually do the household jobs like cooking and cleaning  
PTM9: hmmm... then what kind of appliance you usually used to grind th  
the kitchen? Is it electric mixer grinder or any other traditional manual grin  
P13: I am using the old kind of manual grinding equipment  
PTM9: The one with the heavy rock. Isn't it?  
P13: yes  
PTM9: oh... that is a heavy work... using the rock type old manual grindin  
you using it daily?  
P13: yes  
PTM9: That's may be a reason for not reducing the pain ... At least for fe  
do some simple cooking like chanaathu and subii curuv. You people make

## Screen short three: Main themes, theme and subthemes

The screenshot displays the NVivo Pro software interface. The main window shows a list of nodes with their names and the number of references. The nodes are:

- Clinical contextual factors (2 references)
- Adherence (9 references)
- Accessibility (2 references)
- Affordability (3 references)
- Attitude (5 references)
- Attitude of pt (5 references)
- Attitude of PT (13 references)
- Belief (9 references)
- Expectation (7 references)
- Patient symptom tolerance (3 references)
- Interactional features (2 references)
- Addressing (2 references)
- Negotiation or reflection (3 references)
- Resistance (2 references)
- Self discourse (6 references)

The right-hand pane shows the text of the selected node, "Self discourse", with the following references:

- Reference 1 - 5.25% Coverage: PTO4: Which standard you are studying?
- Reference 2 - 13.94% Coverage: PTO4: Is your college off today? P5:ah, our lectures go for a strike today P5: what is your name?

The interface includes a menu bar (FILE, HOME, CREATE, DATA, ANALYZE, QUERY, EXPLORE, LAYOUT, VIEW), a toolbar with various analysis tools, and a sidebar with navigation options like Nodes, Sources, and Reports.

## Appendix 12: Interview guide for patient

### Warm up questions

1. Can you tell me why you visit the physiotherapy clinic today?
2. How many times you visited the clinic for this particular problem?
3. From where / how you know about physiotherapy treatment?
4. Have you ever had an experience with physiotherapy treatment before?

### Main questions

5. Did you feel any difficulties during the session?
6. Can you tell me any time in your treatment session do you feel you can't follow or any difficulties with particular treatments or advices that provided by the therapist?
7. If yes, what are the reasons that prevent you from follow any particular treatment or advices provided by therapist?
8. In that situation, what was the response of the therapist?
9. If, No which are the reasons that you follow?
10. What you want to say about physiotherapist?
11. How you address the physiotherapist? Did he/she instructed you how to call them?
12. Can you tell me if you are currently using or have been used any other form treatment for this particular condition?
13. Do you have any interest to use any other form of treatment for your condition? Why?
14. Did your physiotherapist provide enough information about your condition and about the treatment?
15. How did the physiotherapist explain to you about your condition and the treatment? ( visual aids, any words that you do not understand)
16. According to you what are the characteristics of an ideal physiotherapist?
17. What did you expect a physiotherapist to be?
18. Did your relationship with your therapist change over time?
19. Do you have any suggestion to improve the therapeutic session?

What was the therapist response when you feel pain or any other symptom during the treatment?



20. What is your opinion about treatment settings? (related to treatment time, treatment environment, privacy)
21. Do you have any difficulties to attend the clinic? ( related to accessibility)
22. What did you expect the treatment settings to be?
23. Do you have any suggestion to improve the therapeutic session?
24. Do you have any other comments you would like to add about?

**Demographic data**

25. What is your name?
26. What is your age?
27. What is your Job?
28. What is your religion?
29. Where are you from?

## **Appendix13: Interview guide for Therapist**

### **Warm up questions**

1. Can you tell me about your experience as a physiotherapist?
2. How would you describe your role in the clinic?

### **Main questions related to the study**

3. What are the characteristics of an ideal patient? Or which kind of patients are easy to handle? (not thinking about their condition, but their personality, how they relate to you)
4. What are the characteristics of an ideal patient therapist relationship? How often do you think you manage to achieve that? Is any things that prevent to create an ideal patient therapist relationship?
5. Is the relationship between therapist and patient the same all the time, or does it change? Over time? With different patients? With different conditions?
6. Does their non-adherence make things difficult?
7. According to your experience what are the reasons for non-adherence to physiotherapy program?
8. Do you find you communicate (educate) better with one group of patients than another?
9. What types of patients do you find it more difficult to deal with?
10. Do you think patients have different expectations now than they did in the past?
11. What do you think patients want from you? What do you expect in return from them?
12. Is there anything about their attitude that you think affects the consultation? ( attitude towards symptom, attitude towards treatment, attitude towards therapist)
13. How do you address patients? Is there any variations in addressing patients?
14. Have you ever felt any challenges from the working environment while you dealing with your patient?
15. What are the professional challenges in your day to day practice?
16. Suggestion to improve professional standards? (documentation, clinical reasoning, assessment)
17. Do you have any other comments you would like to add about?

**Demographic data**

- What is your name?
- What is your age
- What is your job title?
- What are your professional qualifications?
- What is your religion?
- How long have you been working in the outpatient department?

**Appendix 14: Sample semi-structured interview transcript coding of**

**Therapist (PTP19)**

Quotes form the semistructured interview	Relevant themes identifies
<p><i>The people from Hindu religion address the elders Acha/Amma, they are one group, Christians address the elders like Appacha/ Ammachi, is another group. Some other group also there. Once, I had addressed a patient from Christian community like Acha, then they back answered me that he was not Acha because Amma or Acha is not a word to address elderly people from their religion'</i></p>	<p>Address patients</p>
<p><i>'The patient's expected something, but they direct to here. So they came here and attend because of doctoral reference. That kind of patients has reduced the interest to attend and make the bond with us'</i></p>	<p>Patient expectation; Expectation</p>
<p><i>Middle age people are very understandable. Middle aged man, people understand what we are saying. I think I can bitterly adjust with middle aged people. Young age and old age people are bit difficult.</i></p>	<p>Age/ attitude</p>
<p><i>Most of the old age patients do not even allow to touch because their tolerance is very less.'</i></p>	<p>Age/ attitude</p>
<p><i>Some patients do not like to do physiotherapy. They like passively to take medicines and reduce symptoms. Their symptom may be reduce; but actually the pathology will be there. If a patient come to the doctor for treating the same symptoms more than once or twice then doctor's usually referred them to physiotherapy. These type of people say I felt better improvement or I sleep well while taking medicine, but now I feel pain.</i></p>	<p>Patient expectation</p>

## Appendix 15: Sample semi-structured interview transcript coding of

### Patient.

Quotes from the semistructured interview	Relevant themes identifies
<p><i>'Before there was a Philip doctor he was nearly my age. We both like friends'.</i></p>	<p>Same age and gender.</p>
<p>I do not know what physiotherapist do. I thought it is massage.</p>	<p>Expectation</p>
<p>Yes, Some exercise we can't memorise or understand. Initially. Young people its ok they can memorise all. But I could not understand how to do certain exercise initially. I repeatedly ask few times how to do this.</p>	<p>Problem related to ageing</p>
<p><i>'Sir, said there is no specific use for tailum. But I used tailum before came here, I took heat for the pain as well. Still, now I am using tailum for this pain' (P30).</i></p>	<p>Ayurvedham,different opinion</p>
<p>Then ehh...everybody in the house and the elders like grandfathers, grandmothers, father and and mothers depend ayurvedham first. People in our place are using tailum. So like to to use ayurvedham</p>	<p>Believe in ayurvedham</p>

## Appendix 16: Future Dissemination strategy

<b>Publication</b>
<p><b>Socio-cultural factors affecting patient adherence in physiotherapy settings in India.</b> (Journal : Physiotherapy)</p> <p><b>Solidary in physiotherapeutic relationship: An ethnographic discourse study from Indian outpatient settings.</b> (Journal Disability and rehabilitation)</p> <p><b>Patient compliance and therapeutic relationship: An ethnographic discourse study from Indian physiotherapy outpatient settings.</b> (Journal : Communication and medicine)</p> <p><b>Patient Expectation and therapeutic relationship: An ethnographic discourse study from Indian physiotherapy outpatient settings.</b> (Journal: Disability and rehabilitation)</p>
<b>Conference</b>
<p><b>An illustration of the relevance of discourse analysis in physiotherapy research</b> (WCPT conference 2019 Geneva)</p>

